STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from January 26, 2010 through February 5, 2010. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 94. The survey sample totaled 83 residents, which included 40 census residents, 9 admission residents and 33 Stage II residents. Additionally, there was 1 subsampled resident.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to	F 156 156	1. Referenced residents/families will be contacted and informed of appeal procedures liability notices and demand billing procedures. 2. All residents may be affected. 3. Admissions Director will review and revise liability notice procedure and demand billing procedure. 4. Admission Director will report all non-coverage notices to QA.	4/6/10 4/6/10 4/6/10 4/6/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
NHA	Administrator	3/18/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1 the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2 directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records, it was determined that the facility failed to provide notice of termination of benefits for three (R23, R61, R74) out of three residents reviewed. Findings include: 1. Review of the facility's liability notices on 1/27/10 revealed that no notice of Medicare Provider Non-coverage letter (Medicare cut letter)	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 3 was provided for R23, therefore, the resident was not notified when and why coverage was discontinued. 2. Review of the facility's liability notices on 1/27/10 revealed that no notice of Medicare Provider Non-coverage letter (Medicare cut letter) was provided for R61, therefore, the resident was not notified when and why coverage was discontinued. 3. . Review of the facility's liability notices on 1/27/10 revealed that no notice of Medicare Provider Non-coverage letter (Medicare cut letter) was provided for R74, therefore, the resident was not notified when and why coverage was discontinued. Review of facility procedures entitled, "Medicare Demand Billing Procedure" stated that, "if the facility, as a Medicare SNF provider believes, that Medicare will not pay for skilled nursing or specialized rehabilitation services, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered." The procedure did not address when they need to notify the resident or family members. Additionally, the admission packet and the "Resident Nursing Care Agreement" within the admission packet that addressed Medicare Services failed to inform residents about demand billing. On 1/27/10 and 1/28/10, interviews with E4 (Director of Admissions/Community Relations), who is responsible for the Medicare cut letters, confirmed these findings.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Cross refer to F325, example 1 Based on interviews and record reviews, it was determined that the facility failed to immediately notify the resident's physician for one (R26) Stage	F 157	F157 1. Physician has been notified about R26 weight loss. Health shakes were ordered for 3 times per day. 2. All residents have the potential to be affected. 3. Physician will be notified of all significant weight losses. Director of Nursing or Designee will review a sampling of residents with significant weight loss will be checked monthly to make sure physician was notified. 4. Director of Nursing or designee will report findings to QA monthly for three months to determine notification compliance. If necessary, QA will initiate additional action plans.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 5 II sampled resident who had a significant change in condition. Findings include: The facility's policy on "Weight Measurement" stated, "Report to physician weight changes of five pound (sic), 5% or more in a 30-day period, or a 10% change in a 180 day period. Review of R26's weight record on 2/4/10, revealed that she had a significant weight loss of 19.1 lbs. (13.7%) in 3 weeks. There was no evidence found in the clinical record that R26's physician was notified of her weight loss. A dietitian's note, dated 1/14/10, stated that R26 lost 10.5% in one month, however, there was nothing written that indicated that the physician was notified. During an interview with E3 (Assistant Director of Nursing, ADON), on 2/5/10, she stated that when a resident's weight loss was discovered, she notified the dietitian (RD) who addressed the problem. Then the next time the physician was in, he would learn of the resident's weight loss when he signed any order for a supplement that the RD wrote. She also stated that they started residents on supplements ordered by the RD before the physician signs the orders which is in violation of Delaware's Nursing regulations (24 Del. C. 1902 (n) (6)) which only allows registered nurses to follow orders from a licensed physician, dentist, podiatrist, or an advanced practiced nurse. Although the ADON confirmed that it was their policy to notify the physician of a significant change in weight for a resident, this practice of depending on the RD's notes to inform the physician resulted in a system failure in regards to the reporting of R26's significant weight loss.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 6 The facility failed to notify the physician of a significant weight loss for R26 for at least three weeks after it was identified by the RD.	F 157		
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to	F 159	F159 1. N/A 2. All residents that have funds on deposit may be affected. 3. Business Office will provide a locking cash box to the Security Desk to have cash available on evenings and weekends for resident withdrawal. Admission information will indicate changes in cash requesting procedures for all new residents. The approximately 5-10 residents who request cash currently will be informed of the increased availability verbally by accounting clerk. 4. Business Office will monitor cash box weekly.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159	Continued From page 7 the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of residents' trust fund statements on 1/29/10 and interviews, it was determined that the facility failed to make personal funds readily accessible to two (R46 and R67) of six sampled residents. The facility also failed to follow their own procedures stating they allowed residents to withdraw their funds at any time. Findings include: 1. On 1/26/10 during an interview, R46 she stated that she was unable to get her funds on the weekends. 2. . On 1/26/10 during an interview, R67 she stated that she was unable to get her funds on the weekends. An interview with E5 (accountant) on 1/29/10 confirmed that residents have access to their personal funds during the weekdays until 5:30 PM, and not on weekends. She stated that if residents needed funds on the weekends or weeknights when her office was closed, she would hold the funds with security for residents to	F 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159	Continued From page 8 obtain off hours. E5 stated that of 43 residents' trust fund accounts she managed, only a few had requested funds on weekends. Review of facility procedure entitled: "Resident Guest Trust Policy and Procedure", Step III, indicated that "residents may request withdrawals from their fund account at anytime". ...."Immediate withdrawal of funds can be accomplished during regular business hours through the accounting office". The use of security staff in the withdrawal of resident trust funds was not found in the procedures.	F 159		
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to post a notice as to the availability of the results of the most recent survey in a location readily accessible to residents. Findings include: During a tour of the facility on 1/30/10, the results from the last annual and complaint survey were observed in a rack located in the lobby. However,	F 167	F167 1. All residents may be affected. 2. All residents may be affected. 3. Notices will be permanently affixed to the walls in resident areas. 4. Notices will be verified for presence during weekly rounds by Administrator or designee.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 9 there were no notices posted on the second and third resident floors to indicate the availability of the survey results. A small sign was observed posted in front of the activity room door yet this sign was not accessible to most residents. Observation of the activity room during the survey indicated that less than 20 people attended the scheduled activities. This is a repeat deficiency from the 12/22/08 and 11/28/07 surveys. The Plan of Correction (POC) for the 12/22/08 survey indicated that a sign would be posted on the second and third resident floors outside the dining areas and that monitoring of the sign would be done monthly. An interview with E9 (Facility Manager) on 2/1/10 confirmed that the signs were not posted on the floors.	F 167		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility employee records, policies and procedures, and staff interview, it was determined that the facility failed to implement their policies and procedures for screening employees that included a completed background investigation in a timely manner for two of eight sampled employees (E6, E7). E6 (Certified Nurse Aide, CNA) was missing the criminal background check. E7	F 226 F226	1. Referenced employees have had criminal background, adult abuse registry and child abuse registry checks completed. 2. All residents may be affected. 3. Vendor managers have been trained in procedures for completing referenced checks. Payroll Manager will ensure Interview/Hiring Checklist is complete for all new hires. 4. Payroll Manager will report to QA committee the results of new hire checklist completion. If necessary, QA team will initiate additional action plans.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 10	F 226		

(Laundry/housekeeping staff) was missing the adult and child abuse checks. Findings include:

The facility's policy and procedure regarding Abuse, "Screening of Employees" was reviewed. The procedure stated that, "All employees will be screened for a history of abuse neglect or mistreatment of residents or potential indicators of such as a condition of their hire using the following methods.....check on adult abuse registry and child abuse registry and criminal background check".

1. On 2/2/10, a review of the facility employee documents revealed that one of three agency staff (E6), hired on 11/11/09, did not have federal or state criminal background records on file clearing them of any abuse history prior to working with residents. On 2/2/10, an interview with E8 (Payroll/HR Manager) revealed that the review was not completed. On 2/4/10, the surveyor requested the contract for this staffing company to review the facility criminal background requirements for agency's CNA services. E8 stated that there was no contract for the agency.

2. Facility employee documents reviewed for E7 (Laundry/housekeeping agency staff), hired on 10/27/09, revealed that child abuse and adult abuse checks were missing from E7's records. On 2/2/10, an interview with E8 confirmed that the child and adult abuse checks were not done for E7 until 2/2/10 after it was brought to the facility's attention.

An interview with E8 on 2/4/10 revealed that there was a switch in vendors for housekeeping /laundry services on 8/6/09. The contract, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 11 8/6/09, was reviewed for housekeeping/laundry agency services. The contract stated, "Employee Screening" ..., "Contractor's employees are subject to the facility's policies regarding,.., drug screenings and background checks, if required, at the expense of the Facility.....". E8 stated that E7 probably fell through the cracks.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident interview, it was determined that the facility failed to promote care in a manner and in an environment that maintained or enhanced 1 sampled residents' (R67) dignity and respect in full recognition of her individuality. R67 urinated in her recliner in her room several times due to inaccessibility of her call bell and her requests for staff assistance going unheard. Findings include: R67, a 63 year old female, was admitted to the facility on 5/7/09 with diagnoses including corticobasal degeneration (progressive neurodegenerative disease) and anxiety. R67 was coded as continent or in complete control of bowel and bladder function on quarterly Minimum Data Set assessments dated 11/2/09 and 2/1/10. On 1/29/10, R67 was observed blowing into her specialized call bell positioned on the left side of her upper bed and the system activated properly.	F 241 F241	1 Call bell was adjusted to reach resident in all spaces that resident uses in her room. 2 All residents who require assistance to reach the call bell could be affected. 3 In-service will be provided to staff about importance of call bell placement, so residents are able to get help when needed. A sampling of 5 residents will be checked monthly for proper call bell placement by Director of Nursing or designee. 4 Director of Nursing or designee will report results of sampling to QA to ensure call bell placement is appropriate for 3 months.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 12 A CNA responded within a minute. R67 was observed in the recliner chair in her room on 1/27/10 and on 2/3/10 without access to her call bell. On 2/3/10, after speaking with R67 for approximately 45 minutes while she was in the recliner without her call bell, E33 (nurse) confirmed this finding. E33 stated that R67's call bell does not reach the chair and it cannot be moved, but CNA's were to check this resident hourly. However, R67 stated to E33 and the surveyor that this was not being done. While talking with R67 on 2/3/10, she stated that she urinated in her recliner the previous evening (2/2/10) about 9 PM because no one heard her call out when they walked by her room and she had no access to her call bell. When asked how this made her feel, R67 stated, "I didn't like it. I was embarrassed and ashamed." R67 additionally stated that the same thing had happened several other times. Review of CNA flow sheets confirmed that R67 was listed as incontinent on the evening of 2/2/10.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by:	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 13 Based on observation and resident interview, it was determined that the facility failed to have reasonable accommodations for 1 sampled residents (R67) needs. The facility failed to provide R67, who required a specialized call bell, access to a call bell except for when she was in bed. Findings include: R67, a 63 year old female on hospice, had diagnoses including corticobasal degeneration (progressive neurodegenerative disease) and anxiety. Review of a quarterly Minimum Data Set assessment, dated 11/2/09, coded R67 as fully dependent on staff for all care, including toileting. R67 was continent or in control of her bowel and bladder function. On 1/29/10, R67 was observed blowing into her specialized call bell positioned on the left side of her upper bed and the system activated properly. A Certified Nurses Aide (CNA) responded within a minute. R67 was observed in the recliner chair in her room on 1/27/10 and on 2/3/10 without access to her call bell. On 2/3/10, after speaking with R67 for approximately 45 minutes while in the recliner without her call bell, E33 (nurse) confirmed finding. She stated that R67's call bell does not reach the chair and it cannot be moved, but CNA's were to check R67 hourly. R67 stated to E33 and surveyor that this was not done. E33 stated that she did not know why R67 was in her chair at this time (5 PM), that the resident was gotten up for meals and then returned to bed the rest of the time so that she would have access to her call bell. R67 agreed. While talking with R67 on 2/3/10, she stated that	F 246	F246 1 Call bell was adjusted to reach resident in all spaces that resident uses in her room. 4/6/10 2 All residents who require assistance to reach the call bell could be affected. 4/6/10 3 In-service will be provided to staff about importance of call bell placement, so residents are able to get help when needed. A sampling of 5 residents will be checked monthly for proper call bell placement by Director of Nursing or designee. 4/6/10 4 Director of Nursing or designee will report results of sampling to QA to ensure call bell placement is appropriate for 3 months. 4/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 14 she had urinated in her recliner several times because staff did not hear her call out when they walked by her room and she had no call bell access. R67 additionally stated that she had no access to a call bell (usable to her) while in the bathroom. Therefore, she was unable to call when she was finished using the toilet (specialized) and she has had to wait for up to an hour for assistance. Findings were confirmed with E2 (Director of Nursing) on 2/3/10. E2 stated that she would have the issue worked on. On 2/4/10, R67's specialized call bell was found attached to an IV pole in her room. R67 stated that she now had access to her call bell all over her room, but not in the bathroom.	F 246		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations throughout the survey, the environmental tour with the facility maintenance and housekeeping staff on 2/1/10, and staff interviews, it was determined that the facility failed to provide maintenance and housekeeping services necessary to maintain an orderly and sanitary interior. Findings include: 1. Scratched or nicked walls were observed in resident rooms 216, 222, 256, 307, 316, and the wall outside resident room 314. An interview with E9 (Facility Manager) confirmed this finding.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 15 2. Four (4) of six (6) wheelchairs were observed dirty in the hallway area of the second floor on 1/27/10. Also, wheelchairs encrusted with dirt were observed on the second floor dining room hallway (4 of 13 chairs) on 2/2/10. Additionally, brown dirt was observed encrusted on a wheelchair seat on 1/27/10 at 9:06 AM in the third floor hallway outside the dining area. An interview with E13 (nurse) and E20 (CNA) confirmed this finding and had the chair removed from the area to have it cleaned. They stated that the chair belonged to resident R86 who resided on the second floor. Review of cleaning log sheets indicated that approximately six wheelchairs or geri chairs had been cleaned from 11/1/09 to 2/2/10. 3. Observations made during the environmental tour on 2/1/10 revealed a bag of trash on the floor on the second floor Gilpin side soiled linen area. Observations on 2/1/10 at 2:05 PM of the third floor Gilpin hallway "Soiled" room revealed a "Red" or biohazard bag on the floor and one on top of the Biohazard container. Staff interview with E9 confirmed the bags should not had been left on the floor. 4. Observation of resident room 307 on 2/1/10 revealed the moulding on the floor entrance to the room was loose and the hamper in the bathroom was in disrepair. Staff interview with E9 revealed the hamper was owned by the resident. The staff called maintenance staff to repair the door moulding which was a safety tripping hazard. 5. Observation of resident room 356 on 1/31/10 revealed a gap between the bed frame and the	F 253 F253	1.1 Referenced walls will be repaired. 2.1 Wheel chairs have been cleaned. 3.1 Bags were removed and discarded. 4.1 Molding on threshold has been repaired. 5.1 Mattress/bed for room 356 was repaired. 6.1 Referenced dust has been removed. 7.1 Dust pans have been cleaned. 8.1 Chute door will be repaired. 9.1 Dinamap devices have been cleaned. 10.1 Referenced latching mechanism will be repaired or replaced. 2. All residents may be affected. 3. Facility Manager will conduct monthly rounds to ensure damaged walls are identified and repaired as needed. Wheelchairs will be cleaned weekly. Environmental Services Director or designee will review a sampling of 5 wheelchairs for cleanliness monthly. Nursing staff will be inserviced to prevent trash bags/red bags being placed on floors. Environmental Services Director or designee will conduct monthly rounds to identify bags on floors. Facility Manager will	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 16 mattress of about 6 inches. Staff interview with E9 revealed that the mattress was missing a metal piece that kept the mattress in place. An interview with E9 on 2/1/10 revealed the mattress was repaired. 6. Observations of the exhaust vent grills in the soiled linen areas on the second and third floors, Gilpin and Van Buren hallways, revealed thick dust on the grills of the exhaust vents on 2/2/10 during the tour with E9. The soiled linen chute door in the basement soiled linen receiving area was also observed coated with thick dust. 7. Observation of a dust pan stored in the Van Buren soiled area of the second floor revealed encrusted debris on the pan. A new procedure was developed on 2/2/10 to address the cleaning of the dust pans. Prior to 2/2/10, the current and previous housekeeping contractors cleaned dust pans by running them through the kitchen dishwasher. 8. Observations throughout the survey of the soiled linen chute door in the basement revealed the door locking system to be in disrepair keeping the door open. This had the potential for dirty air to get inside the resident units and fire to easily spread into the basement which stored flammable materials (soiled linen). The door did not close when soiled linen was thrown through the chute located in the second and third floor oxygen rooms. An interview with E9 confirmed these findings. 9. On 2/1/10, dirt and dust were observed on the frame of the Dinamap blood pressure/temperature unit. Staff interview with E9 confirmed this finding.	F 253 F253 (cont)	conduct monthly rounds to identify loose moldings at thresholds. Facility Manager will review a sampling of 3 bed frames monthly for proper distances. Environmental Services Director will conduct weekly rounds to identify areas of accumulated dust. Dust pans will be cleaned weekly or as needed by housekeeping staff. Environmental Services Director will review a sampling of dust pans weekly to ensure cleanliness. Chute door will be repaired and kept closed. Dinamap BP unit has been cleaned. Environmental Services Director will check a sampling of Dinamap equipment for cleanliness during weekly rounds. Latching mechanisms for supply room doors will repaired or replaced or alternatives applied. Facility Manager or designee will review a sampling of latching mechanisms during monthly rounds. 4. Facility Manager and Environmental Services Director will submit reports to QA identifying the findings of their respective weekly rounds and sampling inspections. QA team	4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 17 10. On 2/1/10, the locking mechanisms of the supply room/clean linen closets on the Gilpin hallway of the second and third floors were observed in disrepair. Staff interviews with E9, E28, E33 confirmed these findings.	F 253 F253 (cont)	will develop and implement additional actions plans where necessary.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278	F278 1. MDS currently reflects contracture of resident R56's hand. 2. All residents who are risk of development of contractures may be affected. 3. A sampling of MDS section G will be reviewed monthly for accuracy by RNAC. 4. RNAC will report results of sampling to DON/QA. If necessary, additional action plans will be developed based on findings of sampling review.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 18	F 278		

by:
Based on observation, interview, and record review, it was determined that Minimum Data Set (MDS) assessments for 1 sampled resident (R56) did not accurately reflect the residents' status. MDS' for most of 2009 failed to reflect that R56 had a fully contracted hand. Findings include:

Review of the admission Minimum Data Set (MDS) assessment, dated 2/10/06, coded R56's hand ROM as "0-0" (no ROM limitation and no loss of voluntary movement). Review of the 12/12/08 annual and 3/10/09, 6/9/09, and 9/7/09 quarterly MDS assessments, coded R56 as "1-0" for the hand (ROM limitation on one side without loss of voluntary movement). The annual 12/2/09 MDS assessment coded R56's hand as "1-2" (ROM limitation on one side with full loss of voluntary movement).

An OT evaluation, dated 11/12/09, stated, "Left hand contracture into very tight fisted position, c/o (complaints of) pain on attempts to open hand...". R56 was observed throughout the survey with her left hand fully contracted.

On 2/1/10, during an interview with R56's daughter, she stated that her mother's left (L) hand has been contracted like it currently is for 1 1/2 years or so.

On 2/2/10, E31 (nurse) stated when she began employment in the facility about 2 years earlier, R56's L hand was slightly painful, but she was able to fully open her fingers. E31 stated that the resident's L hand had been fully contracted and very painful for about a year.

On 2/2/10, E14 (former RNAC- Registered Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 19 Assessment Coordinator) was interviewed. She stated that another RNAC, no longer employed with the facility, did the MDS assessments for R56 for the past year in the evenings. E14 was unable to locate contraction measurements in the record. The facility failed to implement interventions for R56's fully contracted left hand until 11/09.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to ensure that the care plan was reviewed and	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 20 revised for six (6) sampled residents (R14, R26. R28, R37, R77 and R88). Findings include: Cross refer F318, example #1 1. R14 was readmitted to the facility from the hospital on 8/24/09 and had diagnoses that included Alzheimer's disease, osteoporosis and arthropathy (joint disease). R14 also had a left hand contracture. Readmission orders, dated 8/24/09, included an order for "Splint to L (left) hand apply in AM remove @ HS (bedtime)." A care plan, rewritten on 8/31/09 for the problem "at risk worsening of hand contracture" included the intervention "OT (occupational therapy) consult and tretment (sic) as ordered." The facility failed to revise the care plan to reflect the use of the left hand splint. During an interview on 2/2/10 at 10:15 AM, E14 (nurse) acknowledged that the care plan failed to reflect use of the left hand splint for R14. 2. R37's care plan, dated 1/29/10, for the problem "actual alteration in skin integrity to sacrum" included the intervention "condom cath (catheter) on at HS (bedtime) off in AM." Observations of R37 from 1/29/10 through 2/2/10 during the 7 AM to 3 PM shift revealed that the resident was wearing a condom catheter. During an interview with E14 on 2/2/10, it was determined that since R37 was totally incontinent of bladder, he was wearing the condom catheter to promote healing of his sacral wound. E14 acknowledged that the facility failed to revise the care plan to reflect the use of the catheter around the clock.	F 280 F280	1.1 Care plan has been updated for R14 to reflect the use of splint. 1.2 All residents who use splints may be affected. 1.3 RNAC has been trained on care plan development. A sampling of 5 care plans will be reviewed for accuracy by RNAC or designee monthly. 1.4 Results of sampling will be reported to QA for 3 months to determine care plan accuracy. 2.1 Care plan has been updated for R37 to reflect use of condom catheter. 2.2 All residents who use a condom catheter may be affected. 2.3 RNAC has been trained on care plan development. A sampling of 5 care plans will be reviewed for accuracy by RNAC or designee monthly. 2.4 Results of sampling will be reported to QA for 3 months to determine care plan accuracy. 3.1 Care plan has been updated to reflect R26 weight loss. 3.2 All resident with weight loss may be affected. 3.3 RNAC has been trained on care	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 21 Cross refer to F325, example 1 3. R26 was readmitted to the facility on 12/17/09 following hospitalization for a stoke and C difficile. Review of the weight record revealed that R26 weighed 139 lbs on 12/13/09, the day she left for the hospital, and 119.9 lbs. on 1/8/10, the first time she was weighed in the facility following her hospitalization. This represented a significant weight loss of 19.1 lbs or 9.4% in three weeks. Review of R26's clinical record revealed a dietitian's note, dated 1/14/10, that addressed her significant weight loss and recommended adding health shakes twice a day. R26's care plan for "Potential for Weight Loss", dated 12/18/09, did not indicate the resident's significant weight loss nor the interventions that were recommended. The facility failed to revise R26's "Potential for Weight Loss" care plan to reflect her actual significant weight loss. 4. R88 was admitted to the facility on 10/9/09 with diagnoses including fractured left hip which was surgically repaired, acute DVT (deep vein thrombosis, clot) in the right leg and dementia. Review of R88's clinical record revealed that a black spot was discovered on the resident's left heel on 10/31/09. Her care plan for "The Potential Alteration in Skin Integrity", dated 10/16/09, was revised to note the spot on her heel on 11/4/10 and included an intervention for a heel floater to be worn to offload the left heel. A physician's order, dated 1/11/09, discontinued the	F 280 F280 (cont)	plan development. A sampling of 5 care plans will be reviewed for accuracy by RNAC or designee monthly. 3.4 Results of samplings will be reported to QA for 3 months to determine care plan accuracy. 4.1 Care plan updated for R88 to reflect heel float no longer needed. 4.2 All residents may be affected. 4.3 RNAC has been trained on care plan development. A sampling of 5 care plans will be reviewed for accuracy by RNAC or designee monthly. 4.4 Results of samplings will be reported to QA for 3 months to determine care plan accuracy. 5.1 Care plan has been updated for R77 to reflect decline in locomotion. 5.2 All residents may be affected. 5.3 Care plans are updated following completion of MDS. A sampling of 5 care plans will be reviewed monthly for accuracy by RNAC or designee. 5.4 Results of samplings will be reported to QA for 3 months to determine care plan accuracy. 6.1 Care plan has been updated for	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 22 use of the heel floater since her heel had healed, however, R88's care plan was not revised to indicate this change until it was brought to the facility's attention by the surveyor on 2/4/10. Observation of R88 on 2/4/10 revealed that the resident was not wearing any heel floater on the left foot. During an interview with E13 (LPN) on 2/4/10, she confirmed that R88 had not worn the heel floater since 1/11/10 because her heel was healed. The facility failed to revise the care plan to reflect the current interventions. On 2/4/10, E13 reviewed that care plan and confirmed that it failed to be revised to reflect that R88 was no longer using the heel floater. 5. R77 was admitted to the facility on 4/26/07 with diagnoses including cardiac dysrhythmia, and Alzheimer's disease. R77 had a fall on 12/22/09 and had an X-ray, dated 1/8/10, which revealed that R77 had compression fractures of the spine. The Quarterly Minimum Data Set Assessment (MDS), dated 9/25/09, coded R77's locomotion on unit as 0/0 (independent) and locomotion off unit as 1/0 (supervision). The Significant change MDS assessment, dated 12/21/09, coded R77 as 3/2 (extensive assistance/ 1 person physical assist) in locomotion off the unit and 2/2 (limited assistance/1 person physical assist) in transfer, walk in room and corridor and locomotion on unit. The Resident Assessment Protocol Summary (RAPS), dated 12/21/09, triggered in the area of ADL (Activities of Daily Living) Functional /Rehabilitation Potential and was checked for care planning.	F 280 F280 (cont)	R28 to reflect changes in ADLs and potential for falls. 6.2 All residents may be affected. 4/6/10 6.3 Care plans are updated following completion of MDS. A sampling of 5 care plans will be reviewed monthly for accuracy by RNAC or designee. 4/6/10 6.4 Results of samplings will be reported to QA for 3 months to determine care plan accuracy. 4/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23 Review of the 2/1/10 Potential for falls care plan revealed that R77 transferred and ambulated independently but at times needed an assist of one. Review of the ADL care plan, dated 12/23/09, noted that R77 required limited assistance of one person with ADLs. The facility failed to revise care plans based upon the comprehensive assessment. Neither of the care plans were revised to address R77's decline in locomotion. On 2/1/10, findings were confirmed by E14 (RN Assessment Coordinator). 6. R28 was admitted to the facility on 9/11/02 with diagnoses including diabetes, stroke, and Alzheimer's disease. Review of R28's Annual MDS, dated 7/26/09 and the 10/25/09 Quarterly MDS coded R28's ADL (Activities of Daily Living) self performance as a 0 (independent) in the areas of locomotion on/off the unit and transfer. The Quarterly MDS, dated 1/19/10, indicated a functional limitation in Range of Motion (ROM) of one arm and coded R28's ADL self performance as a 2 (limited assistance) in the areas of locomotion on/off the unit and transfer. On 1/31/10, review of the Assistance w (with)/ADL's and Potential for falls care plans for R28 revealed that there were no interventions regarding restorative approaches including active/passive ROM or rehabilitation services. The problem area in both care plans did not address a limitation with ROM or assessment of the arm limitation. The facility failed to revise the care plans,	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 24 Assistance w/ADL's and Potential for falls, to reflect R28's current status with appropriate interventions. On 2/1/10, these findings were confirmed with E2 (DON).	F 280 F281	1.1 Clarification order received for R17 for Cosopt Opthimolic solution and order updated correctly in MAR.	4/6/10
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility documents, it was determined that the facility failed to meet professional standards of quality for 3 sampled residents (R17, R18, and R37). For R17, the facility failed to meet professional standards by failing to write a telephone/verbal physician's order to clarify which eye was to receive the medication as well as the frequency of the medication, Cosopt. Additionally, a 24 hour chart check failed to identify the discrepancy between the Cosopt order written 11/19/09 and the 11/09 Medication Administration Record (MAR). For R18 and R37, the facility failed to meet professional standards related to the administration of eye and oral medications. Findings include: Two facility policies/procedures were reviewed: The Order Transcription policy/procedure created 12/19/04 and last reviewed on 2/4/10 and the 24 Hour Chart Check policy/procedure created on 12/01/06. The Order Transcription policy/procedure included key procedural points, "1. Verbal or telephone orders must be written legibly and countersigned by physician... 2.	F 281	1.2 All residents may be affected by order transcription errors. 1.3 Nursing staff will receive further training for transcribing orders and 24 hour chart check. Random competencies which include direct observation will be given monthly by Director of Nursing or designee to nurses to make sure they understand and demonstrate both procedures. 1.4 Results of competencies will be reported to QA monthly. 2.1 Eye Drop Procedure reviewed with nurse involved. 2.2 All residents receiving eye drops may be affected. 2.3 In-service to be provided to nurses for proper administration of eye drops. Random competencies which include direct observation will be assigned to nurses randomly each month by Director of Nursing or designee to make sure eye drops are administered correctly.	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 25 Transcription to MAR/TAR (Treatment Administration Record) 3. 24 hour chart check...". The 24 Hour Chart Check policy/procedure included key procedural points, "1. The 24 hour chart check will allow a final look at the day's orders. 2. The chart check will act as a back up system in the event of an order that is not properly transcribed or missed." Steps in the procedure included, "1. 24 hour chart check will be done by the 11-7 charge nurse. 2. The charge nurse must review the most recent orders on every resident chart. 3. The charge nurse will read the most recent order and check it against the MAR, TAR or other relevant place to make sure that the order was transcribed correctly...". Cross refer F309, example #4 1. R17 had a diagnosis of glaucoma and was receiving Cosopt ophthalmic solution 1 drop to the right eye twice a day. From 11/15/09 to 11/19/09, R17 was hospitalized for treatment of a stroke. Review of the readmission orders, dated 11/19/09 included, "Cosopt ophthalmic solution 1 gtt. (drop) left eye daily". Review of the the Nurses' Notes (NN), dated 11/19/09 at 2220 (10:20 PM) stated, "Nurse Practitioner from (name of physician) office requested we maintain old order Cosopt eye gtt (drop) to r (right) eye as oppose (sic) to order which stated to l (left) eye". However, the nurse failed to write a telephone/verbal physician's order to "maintain old order Cosopt" which was 1 drop to the right eye twice a day. Additionally, the nurse went to the computerized MAR and incorrectly entered, Cosopt Ophthalmic Solution 1 drop to right eye daily. Review of the 11/09, 12/09, 1/10 and 2/10 MARs	F 281 F281 (cont)	2.4 Results of competencies will be reported monthly to QA. 3.1 Medication pass competency was completed with charge nurse involved. 3.2 All residents may be affected. 3.3 Random competencies which include direct observation will be assigned by Director of Nursing or designee to nurses randomly each month for med passes. 3.4 Results of competencies will be reported to QA.	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 26 revealed that beginning 11/20/09 through 2/1/10, R17 received Cosopt ophthalmic solution 1 drop to the right eye daily. Also, the 24 hour Chart Check failed to identify that a clarification order was not written and failed to identify the discrepancy between the 11/19/09 physician's orders and the 11/09 MAR. The Nurse failed to follow facility procedures and compare readmission orders with old orders and failed to write the Cosopt order correctly. The facility failed to meet professional standards related to telephone/verbal physician orders. On 2/2/10, during an interview with E2(DON), she stated upon review of the readmission physician's order sheet and NN both dated 11/19/09, that professional standards were not met when the facility failed to write the telephone order for Cosopt in order to clarify the eye receiving the eyedrop and the frequency of administration. Additionally, E2 confirmed that the facility failed to meet professional standards when the 24 hour Chart Check failed to identify that a physician's order was not written to clarify the administration of Cosopt. 2. R37 was admitted to the facility on 3/12/04 with diagnoses that include Multiple Sclerosis, Dementia and Peripheral Vascular Disease. The facility's policy for eye administration, 7.11, from the Nursing Care Center Pharmacy Policy and Procedure Manual- 2007 PharMerica Corp was reviewed. On 1/29/10 at 9:23 AM, E43 (LPN) was observed administering the eye medication Optivar Ophthalmic Solution 0.05%. The physician's	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 27 order stated to administer one drop to both eyes two times a day. E43 placed the eye medication bottle and two tissues in her right gloved hand, entered the resident's room and instructed the resident to open his/her eyes. Using the right hand the employee placed one drop in the lower inner eyelid area of each eye. Each delivered drop hit the inner eye area then ran down R37's cheek. With the right hand E43 dabbed under the R37's eye with a tissue. The employee failed to pull the lower eyelid down to create a pocket in the lower eyelid. During an interview with E2 (Director of Nursing) on 2/2/10 at 1:00 PM, it was stated that the nursing staff was expected to follow PharMerica standard of practice for the administration of eye medications. 3. R18 was admitted to the facility on 2/3/05 with diagnoses that include Epilepsy, Senile Dementia with Delusions and Depressive Disorder. Review of the December 2009 Physician's Order Record revealed a 12/17/09 order for Dilantin 100 milligrams (mg) two capsules by mouth two times a day and a 12/8/08 order for Lexapro 5 mg one tablet by mouth one time a day. During medication administration observation on 1/29/10 at 10:05 AM, E43 (LPN) removed a souffle cup from the medication cart. The cup contained a strip of automated packaged bags that were R18's AM medications. E43 opened each bag and poured the medications into the souffle cup. Then, E43 administered to the resident a total of 10 medications which included four 100 mg capsules of Dilantin and two 5 mg	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 28 tablets of Lexapro which resulted in R18 receiving twice the dose of Dilantin and Lexapro. Potter and Perry's Foundation in Nursing Theory and Practice by Hazel B. M. Heath addresses medication delivery in chapter 31. Medication delivery included the right drug, right dose, right patient/client, right route and right time. The facility failed to meet the standard of practice for medication administration for R18 related to the 5 "rights". On 1/29/10, the findings were confirmed by E43 and E30 (RN Supervisor).	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for six (6) (R17, R31, R37, R60, R67 and R88) out of 33 Stage 2 sampled residents in accordance with the comprehensive assessments and plan of care. The facility failed to transcribe a physician's order for Synthroid (thyroid medication), resulting in R67 receiving the wrong dose for six (6) days. The facility failed to follow written physician orders for Cosopt eye drops and failed to transcribe a verbal order for Cosopt eye	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 29 drops resulting in R17 receiving the eye drop once rather than twice a day for approximately two and one half months. Additionally the facility failed to identify that the 11/19/09 written physician order for the Cosopt eye drops and the directions for the Cosopt eye drops on the MAR were in conflict. The facility failed to follow physician's orders for R60 for the administration of pre-operative eye drops and for R88 for the use of an abduction cushion while in bed. The facility failed to use a Roho cushion for R37 per physician's orders, instead using a gel cushion and failed to follow R31's care plan and implement a chair alarm. Findings include: 1. R67 had a physician's order for Synthroid (thyroid medication) 88 mcg (micrograms) one tablet every other day alternating with Synthroid 75 mcg one by mouth every other day, dated 5/8/09. Based on thyroid function laboratory results, a physician order was written on 9/30/09 to decrease the Synthroid to 50 mcg daily. A nurse's note, dated 9/30/09, stated, "Seen by MD, new orders noted." On 10/6/09, a telephone order was obtained from the attending physician for "change Synthroid 50 mcg daily." A physician progress note, dated 10/7/09, stated, "Notified by nurse that order for synthroid change not transcribed to this pt's (patients) chart (sic) 6 days of not being on 50 instead of 88 mcg that she had been on (sic) of no medical consequences to pt...". Review of the 9/09 and 10/09 Medication Administration Records revealed that the alternating Synthroid dosages ordered on 5/8/09	F 309	F 309 1.1 Synthroid order was corrected and resident receiving correct dose of medication. 1.2 All residents may be affected. 1.3 11-7 Charge nurses complete the 24 hour chart checks each night. A sampling of orders will be reviewed weekly by Director of Nursing or designee to determine correct transcriptions. 1.4 Results of sampling will be reported to QA. If necessary, additional action plans will be developed. 2.1 Order updated as abduction pillow no longer needed. 2.2 All residents may be affected. 2.3 11-7 Charge nurses complete the 24 hour chart checks each night. A sampling of orders will be reviewed weekly by Director of Nursing or designee to determine correct transcriptions. 2.4 Sampling to be reported to QA. If necessary, additional action plans will be developed. 3.1 Chair alarm was replaced in resident's chair. 3.2All residents may be affected. 3.3 Chair alarms will be documented	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 30 were incorrectly given from 10/1/09 through 10/5/09 (5 days) and confirmed failure of the facility to transcribe the 9/30/09 dosage change of Synthroid. The correct dosage of Synthroid was given on 10/6/09. Findings were confirmed with E26 (nurse) on 2/5/10. 2. On 10/9/09, R88 was admitted to the facility post hospitalization for a fractured left hip. A Nurses' Note, dated 10/9/09, stated, "Pass on to 7-3 to clarify dressing & (and) pillow abduction with MD". R88's Physician orders, dated 10/12/09, stated, "Use abduction cushion while in bed". These orders were still current. On 2/4/10, an observation of R88 while in bed revealed that R88 did not have an abduction cushion while in bed. Review of the Treatment Records from 10/09, 11/09, 12/09, 1/10, and 2/10 revealed that there was no record of an abduction cushion noted as being used for R88 when in bed. On 2/4/10, in an interview with E13 (LPN), she confirmed that there was an order for R88 to use the abduction cushion while in bed. E13 accompanied the surveyor to R88's room and looked for the abduction cushion but was unable to find it. On 2/4/10, in an interview with E34 (CNA), she stated that R88 did not have any abduction cushion. The facility failed to follow the physician's order to use an abduction cushion when R88 was in bed. On 2/4/10, findings were acknowledged by E2 (Director of Nursing) who stated after reviewing	F 309 F309 (cont)	in TAR. A sampling of resident treatment orders will be checked monthly by Director of Nursing or designee to make sure orders are followed correctly. 3.4 Results of sampling will be reported to QA. If necessary, additional action plans will be developed. 4.1 Clarification order for R17 was received for Cosopt Opthimolic solution and order updated in MAR. 4.2 All residents may be affected. 4.3 Nursing staff will receive further training for receiving orders and 24 hour chart check procedures. Random competencies which include observation will be given to nurses to make sure they understand both procedures. 4.4 Results of competencies will be reported to QA. If necessary, additional action plans will be developed. 5.1 Further education will be provided to nurses regarding transcription errors and 24 hours chart checks. 5.2 All residents may be affected. 5.3 Nursing staff will receive further	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 31 the physician's order for the abduction cushion and treatment records that the cushion must not have been ordered. 3. R31 was admitted to the facility on 11/13/07 with diagnoses including gait abnormality, dementia, and mood, depressive and anxiety disorders. Review of R31's Fall Risk Assessments, dated 1/13/10 and 10/8/09 revealed that R31 had a high risk potential for falls. The significant change Minimum Data Set Assessment, dated 1/11/10, noted that R31 fell in the past 180 days. R31's potential for falls care plan, dated 1/12/10, included interventions, "chair alarm in recliner". Observations from 1/26/10 through 2/2/10 were made of R31 in the recliner without a chair alarm. The facility failed to follow the care plan intervention of a chair alarm while in the recliner for R31. On 2/2/10, in an interview with E3 (ADON), she confirmed that R31 should have a chair alarm. E3 stated that R31 previously sat in a leather recliner in the alcove and that there was a chair alarm on that recliner. However, the leather recliner was replaced with the current one and she confirmed that there was no chair alarm on R31's current recliner. 4. R17 had a diagnosis of glaucoma and was receiving Cosopt ophthalmic solution 1 drop to the right eye twice a day. R17 was followed by an eye specialist and the medication was part of the specialist's recommendations and incorporated into the physician orders for R17.	F 309 F309 (cont	training for receiving orders and 24 hour chart check procedures. Random competencies which include observation will be given to nurses to make sure they understand both procedures. 5.4 Results of sampling will be reported to QA. If necessary, additional action plans will be developed. 6.1 Resident R37 has received correct cushion. 6.2 All residents may be affected. 6.3 A sampling of residents will be checked monthly by Director of Nursing or designee for treatment order compliance. 6.4 Results of sampling will be reported to QA. If necessary, additional action plans will be developed.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 32 From 11/15/09 to 11/19/09, R17 was hospitalized for treatment of a stroke. Review of the readmission orders, dated 11/19/09 included, "Cosopt ophthalmic solution 1 gtt. (drop) left eye daily". Review of the the Nurses' Notes (NN), dated 11/19/09 at 2220 (10:20 PM) stated, "Nurse Practitioner from (name of physician) office requested we maintain old order Cosopt eye gtt (drop) to r (right) eye as oppose (sic) to order which stated to l (left) eye". The "old order" for Cosopt was 1 drop to the right eye twice a day. There was no telephone/verbal physician's order written to clarify which eye was to receive Cosopt and the frequency of administration. Additionally, the nurse went to the computerized MAR and incorrectly entered, Cosopt Ophthalmic Solution 1 drop to right eye daily. Review of the 11/09, 12/09, 1/10 and 2/10 Medication Administration Records (MARs) revealed that beginning 11/20/09 through 2/1/10, R17 received Cosopt ophthalmic solution 1 drop to the right eye daily. On 11/20/09, the 24 hour chart check which was done failed to identify the discrepancy between the 11/19/09 physician's order (POS) and the 11/09 MAR. The POS written on 11/19/09 included, "Cosopt ophthalmic solution 1 gtt. (drop) left eye daily," while the 11/09 MAR, revealed that the MAR stated Cosopt 1 drop to the right eye twice a day from 11/1/09 through 11/14/09 and beginning 11/20/09, R17's MAR stated Cosopt 1 drop to the right eye once a day. On 2/2/10 at E25 (LPN) placed a telephone call to R17's physician and obtained a clarification order	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 33	F 309		

regarding Cosopt. A verbal/telephone physicians' order was given to discontinue the current Cosopt ophthalmic solution order and then an order was given for Cosopt ophthalmic solution to right eye 1 drop twice a day.

The facility failed to provide the necessary care and services by failing to write a telephone/verbal physician order at the Nurse Practitioner's request. On 2/2/10, during an interview with E2, she stated upon review of the readmission POS and NN both dated 11/19/09, that the facility failed to write the telephone order for Cosopt in order to clarify which eye was to receive the eye drop and the frequency of administration. E2 also confirmed that the 24 hour Chart Check failed to identify that a physician's order was not written to clarify the administration of Cosopt. Additionally, E2 confirmed that this resulted in R17 receiving Cosopt 1 drop to the right eye once a day rather than twice a day for approximately 2 1/2 months.
5. The facility failed to follow a physician's order to administer an eye drop prior to cataract surgery for R60.

Review of the 12/09 physician's order sheet (POS) revealed an order for R60 to receive Cyclopentolate eye drop prior to surgery. However, Cyclopentolate for R60 was not administered to R60 on 1/10/10 prior to surgery.

Review of the Medication Administration Record (MAR) for 12/1/09 and 1/1/10 revealed that the medication was omitted from the MAR and was never entered into the computerized MAR system.

Review of the facility data entry system indicated the medication was not entered into the MAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 34	F 309		

system when the nurse obtained the order from the doctor on 12/22/09. Additionally, the 24-hour chart check failed to identify that R60's Cyclopentolate was not entered on the MAR by E15.

The facility failed to follow a physician's order and failed to ensure the administration of Cyclopentolate, an eye drop medication to R60 prior to surgery. On 2/3/10, an interview with E13 (nurse) revealed that the order was not entered in the MAR on the computer and was not administered to R60.

6. R37 was admitted to the facility on 3/12/04 and had diagnoses that included multiple sclerosis, dementia, spastic quadriplegia and peripheral vascular disease. Additionally, R37 had a history of resolved pressure ulcers.

The 11/9/09 quarterly Minimum Data Set (MDS) assessment indicated that R37 was totally dependent on facility staff for all activities of daily living, was incontinent of bowel and bladder and had a Stage 3 (full thickness skin loss, exposing subcutaneous tissues) pressure ulcer.

Review of the 2/10 monthly physician's order sheet revealed that R37 was to have a ROHO (air flotation) cushion to his wheelchair (w/c). R37's care plan, rewritten on 1/29/10, for "actual alteration in skin integrity to sacrum" included the intervention " ROHO cushion to w/c."

Observations of R37, while in his w/c, on 1/29/10, 2/1/10 and 2/2/10 revealed that he was seated on an uncovered blue gel cushion, instead of a ROHO cushion. The facility failed to follow physician's orders and the plan of care for use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 35 a ROHO cushion for R37. On 2/2/10 at 11 AM, E30 (nurse) observed the cushion being used for R37 with the surveyor and acknowledged that it was not a ROHO. During an interview with E29 (occupational therapist) on 2/2/10 at 12:40 PM, E29 confirmed that the blue cushion was not a ROHO and instead was a gel cushion.	F 309		
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined based on the comprehensive assessment of one sampled resident (R77), that the facility failed to identify a decrease in the resident's abilities to perform activities of daily living (ADL's) and failed to intervene to when R77 had a decline in ADL's. The facility failed to evaluate R77 for a decline in locomotion based on her 12/21/09 Minimum Data Set (MDS) assessment. Findings include: A quarterly MDS assessment for R77, dated 9/25/09, coded the resident as "0/0" or independent with on unit locomotion and "1/0" or	F 310	F310 1. Resident R77 received treatment from PT for gait dysfunction. 2. All residents may be affected. 3. RNAC will report significant changes to Director of Nursing or designee at least weekly to speed up appropriate action. 4. Director of Nursing or designee will report findings to QA. If necessary, additional action plans will be developed.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 310	Continued From page 36 supervision required for off unit locomotion. A significant change MDS, dated 12/22/09, coded R77 as "2/2" or limited, one person assistance with on unit locomotion and "3/2" or extensive, one person assistance with off unit locomotion. On 2/1/10 at 11 AM, R77 was observed in a wheelchair. E21 (CNA) and E34 (CNA) stated that R77 required staff assistance to be pushed in the wheelchair. Review of physician progress notes, dated 11/27/09 and 1/6/10, revealed no concerns or documentation regarding locomotion/ADL decline. E47 (PTA-physical therapy assistant) was interviewed on 2/1/10. E47 stated that R77 was recently seen by therapy for falls and she was previously evaluated and treated in 1/09. R77 was not evaluated for the decline in locomotion as assessed on the 12/21/09 MDS.	F 310		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews and interviews, it was determined that the facility failed to ensure that two (2) residents (R37 and R56) who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 37 The facility failed to provide nail care for R37 and R56. Findings include: 1. R37 was admitted to the facility on 3/12/04 and had diagnoses which included multiple sclerosis, spastic quadriplegia and legal blindness. The 11/1/09 quarterly MDS assessment indicated that R37 was totally dependent on facility staff for all activities of daily living. R37's plan of care for "at risk for worsening of contractures" included the intervention "keep nails clean and trimmed..." Observations on 1/29/10 at 9:25 AM and 2/1/10 at 9 AM revealed the resident had long, thick fingernails which were encrusted with debris. On 2/1/10 at 10:50 AM , R37's fingernails were observed to have been trimmed. 2. R56 has diagnoses including dementia and legal blindness. The annual 12/2/09 MDS assessment coded R56's hand as "1-2" (ROM limitation on one side with full loss of voluntary movement). R56 was totally dependent on staff for all care. Review of R56's care plan for the "potential for development of contractures", dated 12/7/09, listed an intervention to "... keep nails clean and trimmed short to prevent damage to palm of hands if hands are involved...". On 1/29/10, E28 (nurse) showed this surveyor R56's fingernails. E28 was unable to fully open R56's L (left) hand and fingers and the palm was not visible. R56's L pinky laid across the hand digging into her middle finger. Skin on the L middle finger was intact, however, all of the nails on the L hand, especially the pinky, were longer	F 312	F312 1.1 Finger nails were trimmed for R37. 1.2 All residents may be affected. 1.3 All residents have scheduled nail care on bath days and as needed. Supervisor report form will be updated to document that scheduled nail care was completed. 1.4 Supervisor report is given to DON daily for review. 2.1 Nails were trimmed for resident R56. 2.2 All residents may be affected. 2.3 All residents have scheduled nail care on bath days and as needed. Supervisor report will be updated to document that scheduled nail care was completed. 2.4 Supervisor report is given to DON daily for review.	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 38 than those on the right, placing R56 at risk for an alteration in skin integrity. Findings were confirmed with E28 on 1/29/10. Surveyor requested that R56's nails be trimmed and on 2/1/10, they were observed to be neatly cut.	F 312		
F 317 SS=G	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation as indicated, it was determined that the facility failed to ensure that 2 sampled residents (R28 and R56) who entered the facility without limited ROM (range of motion) did not experience a reduction in ROM. The facility failed to adequately assess, care plan and/or follow care plan interventions, and failed to provide preventative care for R28, who experienced a decline in R (right) shoulder ROM and for R56, who experienced a full contracture of her L (left) hand. Findings include: 1. R56 was admitted to the facility on 2/1/06. Diagnoses for this resident included: dementia, legal blindness, degenerative disc disease, osteoporosis, and cervical myelopathy with persistent neck flexion. Review of the admission Minimum Data Set	F 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 317	Continued From page 39 (MDS) assessment, dated 2/10/06, coded R56's hand ROM as "0-0" (no ROM limitation and no loss of voluntary movement). R56 was independent in cognitive skills for decision-making with short-term memory loss. Review of the 12/12/08 annual and 3/10/09, 6/9/09, and 9/7/09 quarterly MDS assessments, coded R56 as "1-0" for the hand (ROM limitation on one side without loss of voluntary movement). The annual 12/2/09 MDS assessment coded R56's hand as "1-2" (ROM limitation on one side with full loss of voluntary movement). On 12/2/09, R56's cognition was coded as moderately impaired. Review of physician orders revealed that on 11/11/09 an Occupational Therapy (OT) consult was written to evaluate for possible use of a carrot (type of splint shaped like carrot) for the left (L) hand. On 12/12/09, OT was ordered 2 times per week for 90 days to address the left hand contracture. On 1/5/10, R56's physician ordered to place OT rehab (rehabilitation) on hold due to R56's MRSA (infection in her PEG tube area-abdomen) and to follow up after a clearance order was given. An OT evaluation, dated 11/12/09, stated, "Left hand contracture into very tight fisted position, c/o (complaints of) pain on attempts to open hand...". Short term goals included, "1. open hand fully c (with) min difficulty 2. staff to clean hand c min difficulty." OT was provided from 11/12/09 through 12/22/09. A 12/8/09 OT progress note stated, "... Attempt to apply carrot orthosis c/o very painful...". An OT progress note, dated 12/22/09, stated, "L hand fisted flexion contracture, painful to move, increase PROM (passive range of motion) of digits able to	F 317 F317	1.1 Contracture was identified for R56 in November of 2009. Therapy was initiated November 2009 and ROM exercises are now provided and documented by caregivers. Routine Tylenol has also been ordered to help prevent pain during ROM. 1.2 All residents with contractures may be affected. 1.3 Range of motions screenings will be done at least annually prior to annual MDS completion by Occupational Therapist to assess ROM. Active or passive ROM will be provided to residents by caregivers and documented in record. Residents will be monitored for pain and treated as necessary. Sampling of ROM documentation will be reviewed monthly by Director of Nursing or designee. 1.4 Results of sampling will be reported to QA. If necessary, additional action plans will be developed. 2.1 Active ROM exercises will be initiated for R28. 2.2 All residents may be affected. 2.3 ROM screenings will be done at	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 317	Continued From page 40 increase cleaning... Reasons for Lack of Progress or Speed of Progress: painful, tenses c (with) PROM... Rehab potential to meet goals (prognosis) good...". An OT note, dated 1/5/10, stated, "Place on Hold 2 (secondary to) MRSA and Contact isolation." Review of R56's record revealed that the facility developed a care plan for "potential for development of contractures" on 12/7/09. In addition to a neck contracture, the facility stated, "... also has decrease (sic) function in hand (left)... will maintain current had (sic) function this review...". Interventions related to the L hand included, "... provide range of motion to left hand when care is being provided. Report any changes or worsening in condition to physician. Medicate for discomfort as needed. OT in progress for L hand contracture." On 12/7/09, another care plan for the "potential for development of contractures" stated that R56 was at risk for worsening of contractures r/t (related to) limited ROM on both sides of body. Interventions included, "... visually compare and record appearance of contractures to the description in the most recent FCS (functional care summary) or to the most recently recorded actual measurements... Offer Tylenol as ordered (sic) pain." Review of the previous care plan for potential for development of contractures, dated 12/17/08, listed only a neck contracture. ADL (activities of daily living) flow sheets (used by CNA's-certified nurses aides), dated 1/13/10 to 2/2/10, were reviewed; they lacked the intervention to provide ROM to the L hand when care was being provided as per the care plan. FCS sheets were reviewed from 9/09 through 1/10 and there was no documentation related to	F 317 F317 (cont)	least annually by OT. Sampling of ROM documentation will be checked monthly for completion by Director of Nursing or designee. 2.4 Results of sampling will be reported to QA. If necessary, additional action plans will be developed.	4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 317	Continued From page 41 contractures. Additionally, the clinical record lacked actual contracture measurements, including OT. R56 was observed throughout the survey with her left hand tightly contracted and no splint devices in place. During an interview with E27 (CNA assigned to resident) on 1/29/10, E27 stated she was unable to do ROM to R56's L hand because "she screams from pain." When this surveyor requested to see R56's L hand fingernails, E27 declined and told the surveyor to get a nurse. Consequently, on 1/29/10, E28 (nurse) showed this surveyor R56's nails. R56 hollered out loud when her L hand was manipulated. E28 was unable to fully open R56's L hand and fingers and the palm was not visible. On 2/1/10, R56's daughter performed ROM on her mother's L hand (had been taught by OT) and screams were audible in the hallway. During an interview on 2/2/10, E29 (OT) confirmed that he had not seen R56 for her L hand contracture until 11/09. When asked if R56 had a L hand splint or device in place prior to his evaluation in 11/09, he stated not unless she came to the facility with one (R56 did not have a hand contracture on admission). E29 additionally stated that annual contraction measurements have not been done in the facility since approximately 2008 when he was told not to do them anymore. E29 confirmed that it would have been better if R56 was referred to him sooner. On 2/1/10, during an interview with R56's daughter, she stated that her mother's L hand has been contracted like it currently is for 1 1/2 years or so. She further stated that she did not recall any devices used in the facility until the carrot was	F 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 317	Continued From page 42 tried in 11/09. When asked if her mother had previously received ROM, she stated that she was unsure, "it was probably too painful." On 2/2/10, E31 (nurse) stated when she began employment in the facility about 2 years earlier, R56's L hand was slightly painful, but she was able to fully open her fingers. E31 stated that the resident's L hand had been fully contracted and very painful for about a year. Review of the 1/10 POS (physician order sheet) revealed an order for Tylenol 325 mg 2 tablets (650 mg total) every 4 hours as needed (prn) for pain/ fever. The MAR (medication administration record) was reviewed from 8/09 through 1/10 and revealed that R56 received prn Tylenol 0-2 times per month. On 2/3/10, findings were discussed with E2 (Director of Nursing). E2 confirmed that contracture measurements or description of contractures as per R56's care plan were not current facility practices. She stated that contracture measurements have to be specifically ordered for residents and none were ordered for R56. E2 confirmed that L hand ROM during care as per the care plan was not being done, and she stated that R56 had no previous interventions in place prior to 11/09 when an OT evaluation was ordered. In review, R56 was admitted to the facility without any ROM limitations to the left hand and on 12/2/09, she was determined to have full loss of motion of her L hand. The facility failed to accurately and adequately assess R56 for contractures to determine changes, they failed to provide preventative and timely interventions in	F 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 317	Continued From page 43 an attempt to maintain or prevent a worsening of her L hand contracture, and the facility failed to follow care plan interventions, including ROM with care by CNA's and they failed to medicate R56 adequately prior to ROM to decrease pain so ROM could be done more effectively. 2. Review of R28's quarterly Minimum Data Set (MDS) assessment, dated 1/19/10, indicated a functional limitation in ROM (range of motion) of one arm and locomotion on/off the unit required a limited assist of one person. Review of the annual MDS, dated 7/26/09, and quarterly MDS, dated 10/25/09, indicated that R28 had no limitations in arm ROM. The resident self propelled in a wheelchair on the unit and required one person physical assistance off the unit. R28 experienced a decline in self performance for locomotion on/off the unit from independent to one person assistance. E45 (Registered Nurse Assessment Coordinator in training) was interviewed on 1/29/10. E45 stated that the assessment information regarding arm limitation was received from the resident and a nurse, she was unable to recall which arm was limited, and she stated that R28's current nurse (E28) knew the resident had limitations, but did not know which arm or if both arms. E45 stated that she should have documented her assessment and she would ask the resident which arm and then inform the physician of the change in arm ROM. R28 failed to receive any therapies, ROM or restorative therapies. After speaking with the resident, E45 stated it was the right arm which had a decline in ROM limitation.	F 317		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 44 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that two (R14 and R37) residents with a limited range of motion, received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Findings include: 1. R14 was admitted to the facility on 11/15/00 with diagnoses that included Alzheimer's Dementia, osteoarthritis, osteoporosis and degenerative joint disease. MDS assessments from 1/13/09 through 11/23/09 indicated that R14 had a limitation in range of motion (ROM) of one hand with full loss of voluntary movement. Review of the clinical record revealed a "Therapy/Nursing Communication Memo," dated 8/12/08 which stated, "...continue use of "carrot" contracture splint for left hand." A second undated therapy communication memo stated "Please wear carrot splint orthosis to L hand all day, all night. Remove for daily hygiene and reapply." The facility developed a care plan for the problem "at risk worsening of hand contracture." Although	F 318 F318	1.1 Resident R14 currently using carrot splint as ordered. 4/6/10 1.2 All residents being re-admitted may be affected. 4/6/10 1.3 Readmission procedures will be updated to use pre-existing orders in computer. All order changes will be discussed with physician. Nurses will receive in-service regarding re-admission procedure. A sampling of admissions will be checked for compliance. 4/6/10 1.4 Results of sampling will be reported to QA. If necessary, additional action plans will be developed. 4/6/10 2.1 ROM exercises initiated for R37 by caregivers. 4/6/10 2.2 All residents may be affected. 4/6/10 2.3 Active and Passive ROM will be provided by caregivers and documented. A sampling of records will be reviewed each month for completion of ROM. 4/6/10 2.4 Results of sampling will be reported to QA. If necessary, additional action plans will be developed. 4/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 45	F 318		

the interventions included "OT (occupational therapy) consult and tretment (sic) as ordered," the facility failed to include the specific use of the "carrot" splint for R14.

The Treatment Record (TAR) from 7/1/09 through 8/21/09 documented that a left hand "carrot" splint was applied in the AM and removed at bedtime.

R14 was hospitalized from 8/21/09 through 8/24/09. Facility readmission orders included an order for the left hand splint to be applied in the AM and removed at bedtime. The TAR from 8/24/09 through 10/3/09 indicated that the splint was applied as ordered.

On 10/3/09, R14 was again hospitalized until 10/8/09. Upon R14's return to the facility, the readmission orders failed to include an order for the left hand splint. Review of the TAR from 10/8/09 through 2/2/10 lacked evidence of use of a left hand splint for R14.

During an interview on 1/27/10, E26 (nurse) stated that R14 had a left hand contracture and that the resident was not receiving range of motion services and did not have a splint device in place.

Review of R14's "ADL (activities of daily living) Plans of Care," dated 10/9/09 to present, which addresses the care the CNAs (certified nurse's aide) are to provide, included under positioning "use carrot contracture splint for left hand." During an interview on 1/29/10 at 2:00 PM, E42 (CNA) stated that R14 used to have a "carrot" but doesn't any longer. E42 also stated that she sometimes places a rolled washcloth in R14's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 46	F 318		

hand, but that placing of a "carrot" is not listed in her day shift "Accu Nurse" (computerized audio program which instructs aides what care/interventions are to be provided for each resident) flow record.

Multiple observations of R14 on 1/26/10, 1/29/10, 2/1/10 and 2/2/10 revealed that the resident did not have a carrot splint or a rolled washcloth in place in her left hand. On 2/2/10 at 10:15 AM, R14's left hand was observed in the presence of E42. The skin of the left palm was reddened, but intact. R14 said "ouch" and drew back her hand when the palm was touched.

On 2/2/10 at 12:45 PM during an interview with E29 (occupational therapy) it was acknowledged that staff should still be applying the carrot splint to R14's left hand and that it should have been continued after her readmission to the facility on 10/9/09. The facility failed to ensure that R14's splint was reordered and applied after her readmission on 10/8/09.

2. R37 was admitted to the facility on 3/12/04 and had diagnoses that included multiple sclerosis (MS) and spastic quadriplegia. MDS assessments from 8/10/08 through 11/1/09 indicated that R37 had range of motion (ROM) limitations on both sides of the body of the arm, hand, leg, foot and other limitation or loss. These same MDS assessments also indicated that R37 had partial loss of voluntary movement of the arms and hands and full loss of voluntary movement of the legs, feet and other.

An OT (Occupational Therapy) evaluation was completed on 9/25/08 which stated that R37 had a history of bilateral upper and lower extremity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 47 contractures and was to be placed on a ROM program on the nursing unit. Review of the clinical record revealed that the last documented range of motion measurements were dated 9/25/08. The facility developed a care plan for the problem "at risk for worsening of contractures related to spastic MS" which included the intervention, "provide range of motion to all joints as tolerated TID (three times a day) x 10 min." Review of R37's clinical record lacked evidence that the resident was on a restorative program. The facility failed to provide ROM three times a day as tolerated as per the OT evaluation and the plan of care. During an interview with E14 on 2/2/10 at 10:15 AM, E14 acknowledged that there was no evidence in the clinical record that R37 was receiving ROM as per the plan of care.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain an environment free from accident hazards as evidenced by resident accessible hazardous	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 48 supplies, soiled linen chute and biohazard waste containers, and cords in R31's room that posed a potential for a tripping hazard. Findings include: 1. Throughout the survey, doors to the clean linen/supply rooms on the second and third floors were observed open and contained items such as razors, perineal cleanser, lotions, and other personal supplies that were accessible to residents. Interview with E11(Housekeeping Manager) confirmed this finding during the environmental tour. On 2/2/10 at 1:47 PM the 2nd floor supply room door was observed opened. E33 (nurse) stated that the supply room doors were supposed to be kept closed but not locked and that anything that needs to be locked was placed in the locked treatment supply room. She stated that nursing staff was supposed to keep the clean linen/supply room doors closed to keep residents from going into the room. She stated that the locking mechanism on the door to close the doors was defective. The supply room doors had a sign on them which stated "Keep doors closed. " Observation on 2/4/10 at 8:15 AM with E13 (nurse) and E28 (nurse) of the clean linen/supply rooms on the second floor revealed that both the supply room doors were open. The door locking systems were in disrepair on both doors. Individual interviews with E13 and E28 confirmed the doors were to be kept closed and that they were unaware that the locking mechanisms were in disrepair. E28 stated that there were about three residents on the second floor that wandered in the facility. 2. Observation of the third floor oxygen supply	F 323 F323	1.1 Clean Linen supply doors will have latching mechanisms repaired/replaced. Nursing staff will be inserviced to keep supply closet doors closed and latched. 2.1 Oxygen supply room door has been repaired. 3.1 Biohazard room doors will have mechanical locks installed. 4.1 Cord has been moved in resident R31's room. 2. All residents may be affected. 3. Environmental Services Director or designee will check a sampling of supply closet doors for closure during weekly rounds. Facility Manager will check a sampling of oxygen supply room doors for proper operation during weekly rounds. Facility Manager will install locking mechanisms to referenced doors. Facility Manager will inspect a sampling of 5 resident rooms monthly for similar safety hazards. 4. Facility Manager and Environmental Services Director will submit reports to QA identifying the findings of their respective weekly rounds and	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 49 room on 2/4/10 at 8:15 AM revealed that the door was unlocked. The oxygen supply room contained the soiled linen chute which was accessible to residents, presenting a hazard. Interview with E13 confirmed that the door lock system was malfunctioning. 3. Throughout the survey, the biohazard rooms, which contained hazardous waste, were observed unlocked and accessible to residents on the second and third floors. Staff interview with E11 confirmed this finding. 4. R31 was admitted to the facility on 11/13/07 with diagnoses including gait abnormality, dementia, depression and mood and anxiety disorders. Review of R31's Fall Risk Assessments, dated 1/13/10 and 10/8/09 revealed that R31 had a high risk potential for falls. The significant change Minimum Data Set (MDS) Assessment, dated 1/11/10, noted that R31 fell in the past 180 days. This same MDS coded R31 as extensive assistance for both, "walk in room" and "walk in corridor". However, observations revealed that R31's ambulation varied during the survey. On 1/27/10, R31 was observed using a rolling walker while ambulating with hands on assistance being provided by a Certified Nurse Assistant (CNA) On 1/29/10, R31 was observed walking with the rolling walker out of his room independently. A few minutes later, R31 was observed walking alone using the rolling walker and with verbal guidance from E41 (RN), from his room to the dining room.	F 323 F323 (cont)	sampling inspections. QA team will develop and implement additional actions plans where necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 50 On 10/27/10, an observation of R31's room revealed that an electrical cord from the air mattress was strung across from the foot of the bed to the dresser. Additionally, there was a gray cord from the air mattress base under the foot of the bed to the air mattress. Both cords were hanging a few inches off the floor. The other cord was a cable cord that was coming from under the foot of the bed hanging 6" off the floor at the foot of the bed to approximately 2 feet off the floor next to the dresser where it attached to the TV. The facility failed to ensure that R31's environment remained as free of accident hazards as was possible due to the cords which provided a potential tripping/accident hazard. On 1/27/10 at 1:00 PM, E25 (LPN) confirmed that the cords were a safety/potential tripping hazard and stated that she would call maintenance to work on it.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 51 and review of facility policy, it was determined that the facility failed to maintain acceptable parameters of body weight for 2 residents (R26 and R99) sampled. The facility failed to implement dietary interventions for both residents who had weight loss. Additionally, the facility failed to obtain a readmission weight for R26 after the resident returned from the hospital. Subsequently, when R26 had a sudden weight loss the facility failed to notify the physician. Findings include: 1. R26 was originally admitted to the facility in 10/08 with a history of cerebrovascular accidents (CVA's - strokes). Review of R26's weight record from 9/09 to 12/09 revealed that her weight was stable between 134 lbs. and 139 lbs. R26 was hospitalized three times between 12/6/09 and 1/27/10. A history of her hospitalizations with diagnoses follows: 12/6/09 - 12/11/09: CVA 12/13/09 - 12/17/09: CVA and C-diff (bacterial infection that causes gastroenteritis) 1/22/10 - 1/27/10: Hemorrhagic encephalomalacia (softening of brain tissue secondary to bleeding) R26's weight record indicated that she weighed 139 lbs on 12/13/09, the day she was admitted to the hospital. The next monthly weight recorded for R26 was 114 lbs. on 1/7/10 and a reweight was done on 1/8/10 which was 119.9 lbs. This represented a significant weight loss of 19.1 lbs. or 13.7% in 3 weeks.	F 325 F325	1.1 Weight loss for R26 addressed and interventions such as health shakes have been initiated. 1.2 All residents may be affected. 1.3 Dietician will provide summary of all charts reviewed to DON or designee to determine that all interventions are followed through. Director of Nursing or designee will check a sampling of charts for completion of dietician orders. 1.4 Results of findings will be reported to QA. QA team will develop and implement additional actions plans where necessary. 2.1 Orders for R99 were corrected in MAR to include Ensure pudding. 2.2 All residents may be affected. 2.3 11-7 Charge nurses complete the 24 hour chart checks each night. A sampling of orders will be reviewed weekly by Director of Nursing or designee to determine correct transcriptions. 2.4 Results of sampling will be reported to QA. QA team will develop and implement additional actions plans where necessary.	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 52 The facility's policy on, "Weight Measurement" stated that, "Residents are weighed on admission and monthly unless otherwise ordered by nursing or the attending physician, to monitor the resident's condition." R26's nursing assessment, dated 12/17/09, lacked evidence that a readmission weight was obtained when she returned from the hospital. Review of R26's clinical record revealed a dietitian's note, dated 1/14/10, which stated, "Wt (weight) 119.9# (pounds) decrease 10.5% x 1 mo. Confirm w/rewt. (with reweight). Meal completion fair. Rec (recommend) H/S (healthshakes), tid (3 times /day) b/w (between) meals, if accurate." Review of R26's clinical record on 2/4/10, lacked evidence that healthshakes were ordered for the resident nor were any subsequent RD notes found after 1/14/10. On 2/4/10, during an interview with E12 (dietitian), she stated that she was waiting for the reweight to be done and was not aware that the 119.9# was a reweight. She was planning to follow-up after she obtained a reweight and was unaware that the resident had been out to the hospital in the interim. She stated that R26, "was not on my weekly list" despite knowing that a potential significant weight loss had occurred. When asked if she usually did an assessment when a resident returns from the hospital, E12 stated that she usually waits until the care plan meeting two weeks later. She also stated that she should have ordered the healthshakes for R26 when she wrote the note on 1/14/10.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 53 Review of R26's January, 2010 flow sheet revealed that of 71 meals served that month, she consumed 50% or less of 39 meals. On 2/5/10, during an interview with E3 (ADON), she stated that she was responsible for monitoring residents' weights. She stated that a weight should be done when a resident is readmitted and that she should be notified of the weight so that it could be entered into the weight record. The facility's policy was to obtain a reweight if there was a difference of 5 lbs. or more from the previous weight. When the weight difference was verified, the dietitian and physician should be notified. When R26 returned from the hospital on 1/27/10, her nursing assessment indicated that she weighed 112.7 lbs. The facility failed to adequately assess R26's weight loss and provide dietary interventions. Additionally, the facility's dietitian failed to follow-up in a timely manner on this resident's significant weight loss. 2. R99 was admitted to the facility on 8/27/09 with multiple diagnoses including congestive heart failure, diabetes mellitus, coronary artery disease, pulmonary hypertension and major depressive disorder. Upon admission, R99's weight was 156.8 lbs. Review of her weight record revealed that her weight on 2/2/10 was 130 lbs which indicated that she had a significant weight loss of 26.8 lbs. or 17% in six months. Review of R99's flow sheet for 12/09 revealed	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 54	F 325		

that of 92 meals served, she consumed 25% or less of 53 meals. Her flow sheet for 1/10 revealed that of 91 meals served, she consumed 25% or less of 56 meals.

Observations were made of R99 in the dining room throughout the survey. During breakfast she only ate a bowl of bran flakes but left the milk. At lunch time, she only ate a few bites of her meal. When asked why she was not eating much, R99 stated, "I don't like the food here." On 2/3/10 at 11:45 AM, the resident was observed sitting outside of the dining room eating a bag of "Cheetoes."

Hospice services were ordered for R99 in 12/09. The hospice nursing note, dated 12/24/09, stated, "7% wt (weight) loss in 30 days; decrease appetite...offer foods pt (patient) enjoys." Subsequent hospice notes, dated 1/6/10, 1/14/10, 1/18/10, 1/25/10 and 2/1/10, all stated that the resident did not like the food and to offer food she enjoys.

Dietitian's (RD) notes from 10/09 through 1/10 stated that R99's intake was poor. The RD (E12) note, dated 10/15/09 stated that Glucerna (nutritional supplement) was ordered three times per day on 10/9/09. The note dated 1/14/10 recommended an increase of the Glucerna to four times per day and also to add Ensure Pudding (nutritional supplement) twice a day. The note also stated, "May also offer pleasure foods." A note, dated 1/28/10, stated, "Resident often buys 'chips & soda' throughout the day, 100% completion. May offer chips w/meals as possible incentive to complete meal."

Review of R99's clinical record revealed that an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 55	F 325		

order was written on 1/14/10 to increase Glucerna to four times a day and add Ensure Pudding twice per day. Her care plan for "Potential for Weight Loss" was also updated on 1/14/10 to include the increase in Glucerna to qid (four times/day) and the addition of Ensure pudding.

R99's Medication Administration Records (MAR), dated 1/1/10 through 2/4/10 were reviewed. The MAR's indicated that she was given the Glucerna four times a day from 1/14/10 through 2/3/10, however there was no evidence that the Ensure Pudding had been given. The investigation concluded that the order for the Ensure pudding was not transcribed onto the MAR. Furthermore, the 24-hour chart check, which was signed off as completed, failed to identify the omission of the pudding on the MAR. Findings were confirmed by E26 (nurse) and E3 (ADON) on 2/4/10.

On 2/4/10, during an interview with E12, she stated that she had spoken to the resident about her food preferences once or twice. She stated that they talked about offering her "pleasure foods" like chips with her meals. When asked if she reviewed the resident's psychology notes, she stated that she had not.

On 2/4/10, during an interview with E10 (Food Service Director), she stated that they had tried to offer R99 alternates, but that the resident just "seemed anxious to leave the dining room at meal times." She stated that they had discussed providing chips with her meals but they had not tried this approach yet.

Review of R99's clinical record also revealed that she had a consult with the facility's psychiatrist on 4/19/09. The assessment was Schizoaffective

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 56 disorder type 2 and depression. She was on the following psychotropic medications: Abilify 15 mg; Depakote 1000 mg and Zoloft 100 mg daily. The note stated that, "Her sleep and appetite is good." Additionally, R99 was being followed weekly by the facility's psychologist for "supportive therapy." The psychologist's notes for 11/09 through 2/10 indicated that R99 was very depressed and had lost her interest in eating. There was no evidence that the facility's psychiatrist was called in for a follow-up consultation to review or reevaluation of her medications since she lost her appetite. Review of R99's Physician's Order Record, dated 12/9/09, revealed that she was still receiving the same dose of Zoloft and Depakote and the Abilify was reduced to 10 mg since her last psychiatry consult in 4/09. R99's care plan for depression, dated 11/16/09, listed "Request psych evaluation if indicated," as an intervention. On 2/5/10, during an interview with E2 (DON) she stated that the facility's psychologist communicates with the resident's medical doctor regarding the effectiveness of their psychotropic medications but not with the psychiatrist. The facility failed to implement interventions to address R99's weight loss and poor appetite. Additionally, they failed to have an effective system in place for staff to communicate issues of mood and loss of appetite with each other in order to coordinate care to address problems that may contribute to a resident's weight loss.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 57 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that five sampled residents (R37, R39, R43, R67 and R89) drug regimens were free from unnecessary drugs. The facility failed to have an indication for long-term use of Optivar eye drops for R37. The facility failed to have an indication for use of Tylenol twice daily for R89 and failed to monitor it's effectiveness. The facility failed to monitor R67's laboratory studies while administering Pravastatin (for elevated cholesterol and triglycerides) and failed to provide	F 329 F329	1.1 Diagnosis was added for R89. Pain assessment added to MAR. 1.2 All residents may be affected. 1.3 Entry of diagnosis codes for medications will be added to computerized MAR during regularly scheduled quarterly care plans. Nurses will be inserviced on importance of obtaining diagnosis from physician. A sampling of physician order sheets will be reviewed monthly to check that diagnoses are present. 1.4 Results of samplings will be reported to QA. QA team will develop and implement additional actions plans where necessary. 2.1 Diagnosis has been received for R37's record from physician. 2.2 All residents may be affected. 2.3 Entry of diagnosis codes for medications will be added to computerized MAR during regularly scheduled quarterly care plans. Nurses will be inserviced on importance of obtaining diagnosis from physician. A sampling of physician order sheets will be reviewed monthly to check that diagnoses are present.	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 58 a diagnosis for the long-term use of antihistamine therapy for R43. The facility failed to have an indication for use of calcium and magnesium and also failed to have behavior monitoring sheets for the use of Ativan for R39. Findings include: 1. Review of R89's medication regimen revealed the resident was receiving Tylenol twice a day. The facility failed to have an indication for use of this medication (no diagnosis) and failed to monitor the effectiveness of the medication. During an interview with E2 (DON) on 2/2/10 at 4:40 PM, E2 acknowledged that there was no indication for use of Tylenol for R89 and that there was no evidence that the facility was monitoring for it's effectiveness. 2. Review of R37's medication regimen revealed the resident had been receiving Optivar eye drops since 10/6/08. The clinical record lacked an indication for this medications use. During an interview with E14 (nurse), she acknowledged that there was a lack of indication for use of the Optivar eye drops for R37. 3. Review of R67's clinical record revealed that she was on the cholesterol lowering medication Pravachol since admission to the facility on 5/7/09. Review of the 1/10 Physician Order Sheet revealed that R67 had no routine laboratory tests ordered. The only lipid (fat) and liver function studies found in the clinical record were dated 9/12/08 (8 months prior to admission to the facility). The laboratory tests revealed an elevated cholesterol level of 269 (normal 0-200). Findings were confirmed with E2 (Director of	F 329 F329 (cont)	2.4 Findings of review will be reported to QA. QA team will develop and implement additional actions plans where necessary. 3.1 Lab tests were ordered for resident R67. 3.2 All residents may be affected. 3.3 Pharmacy consultant will be inserviced on the need to identify residents requiring labs and include missing labs on his report. Pharmacy Consultant will include a report of missing labs for residents on statin drugs. 3.4 QA will review Pharmacy Consultant report for 3 months to ensure the inclusion of missing labs. QA team will develop and implement additional actions plans where necessary. 4.1 Medication was discontinued for R43. 4.2 All residents may be affected. 4.3 Entry of diagnosis codes for medications will be added to computerized MAR during regularly scheduled quarterly care plans. Nurses will be inserviced on importance of obtaining diagnosis from physician. A sampling of physician order sheets will be reviewed monthly	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 59 Nursing) during an interview on 2/1/10. E2 stated that facility practice was to check lipid profiles every 6 months. E2 confirmed that R67 failed to receive proper monitoring for Pravachol since being admitted to the facility 7 months earlier. E2 subsequently spoke to E40 (MD) on 2/1/10 and lipid and liver function labwork was ordered. 4. R43 was admitted to the facility on 11/15/06 with multiple diagnoses including multiple sclerosis, depression and anxiety disorder. Review of R43's Physician Order Record, dated 12/9/09, revealed orders for Loratadine (an antihistamine), 10 mg daily. This medication was originally ordered on 12/31/08, however, no diagnosis could be found to justify its use. Review of R43's clinical record revealed a Medication Regimen Review Sheet, dated 12/29/09, with a note from the pharmacist that stated, "This resident is currently on long term anti-histamine therapy with Loratadine since 8/09. Please consider evaluating long term use of this medication, and if appropriate, consider either discontinuation or changing order to prn (as needed). If continued routine use is still indicated, please add appropriate documentation to clinically support long term use." The physician responded at the bottom of the sheet under "Disagree", "...Have tried in past to d/c (discontinue)." On 1/29/10, during an interview with R43, the resident stated that she did not know that she was on an antihistamine and that she did not have allergies or sinus problems. She also stated that she thought that she was on too many	F 329 F329 (cont)	to check that diagnoses are present. 4.4 Results of samplings will be reported to QA. QA team will develop and implement additional actions plans where necessary. 5.1 Diagnosis was added and behavior sheet was initiated for R39. 5.2 All residents may be affected. 5.3 Entry of diagnosis codes for medications will be added to computerized MAR during regularly scheduled quarterly care plans. Nurses will be inserviced on importance of obtaining diagnosis from physician. A sampling of physician order sheets will be reviewed monthly to check that diagnoses are present. A sampling of residents requiring behavior monitoring will be reviewed monthly to check for behavior forms. 5.4 Finding of behavior form samplings will be reported to QA for 3 months. Findings of diagnosis sampling will be reported to QA. QA team will develop and implement additional actions plans where necessary.	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 60 medications. On 2/3/10, during an interview with E40 (Medical Director), when asked why R43 was on long-term antihistamine therapy, he stated that he was not sure since it was ordered further back than what was in her current record. He stated that it was probably used to treat perennial rhinitis (chronic nasal drip), but that he would discontinue the medication and monitor her symptoms. The facility failed to have documented justification for the long-term use of antihistamine therapy for R43. 5. Review of R39's 1/10 Medication Administration Record revealed lack of an indication for MgOxide (Magnesium) 400 mg 2 times a day and for Oyster Shell Ca/D (Calcium with Vitamin D) 500-200 mg unit 1 tablet 2 times a day. Additionally, R39 received Ativan 1 mg 2 times a day for anxiety and no behavior monitoring sheets were found for the use of Ativan. Findings were confirmed with E2 (Director of Nursing) on 2/2/10.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility documents, it was determined that the facility failed to ensure that one resident (R18) receiving Dilantin (medication for Epilepsy) was	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 61 free of a significant medication error. Findings include: R18 was admitted to the facility on 2/3/05 with diagnoses that included Epilepsy, Senile Dementia with Delusions and Depressive Disorder. Review of the 12/09 Physician's Order Sheet revealed a 12/17/09 order for Dilantin 100 milligrams (mg) two capsules by mouth two times a day and a 12/8/08 order for Lexapro 5 mg one tablet by mouth one time a day. During a medication administration observation on 1/29/10 at 10:05 AM, E43 removed a soufflé cup from the medication cart. The cup contained a strip of automated packaged bags that were R18's AM medications. E43 opened each bag and poured the medications into the soufflé cup. E43 administered the resident a total of 10 medications, which incorrectly included four 100 mg capsules of Dilantin and two 5 mg tablets of Lexapro. During reconciliation, it was revealed that there were two Millennium Pharmacy bags with an automated date and time of 1/29/10 at 8 AM. Each bag also showed an automated name and dose of each medication. In accordance with a facility provided document from Millennium Pharmacy, Dilantin "is an anticonvulsant medication used for treating tonic-clonic (grand mal) and partial seizures." Under the section entitled "How To Use This Medicine" it was stated, "Do not take 2 doses at once."	F 333 F333	1. Nurse completed medication pass competency which included direct observation. Physician notified of medication error. Resident suffered no ill effects as a result of medication error. 4/6/10 2. All residents may be affected. 4/6/10 3. Director of Nursing or designee will assign medication pass competencies which include direct observation to a sampling of nurses monthly. 4/6/10 4. Findings will be reported to QA. QA team will develop and implement additional actions plans where necessary. 4/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 62 In accordance with the State Operations Manual Appendix PP (rev. 52), 9/25/09, page 423, Dilantin is under the drug category which has a Narrow Therapeutic Index (NIT). "If the drug is from a category that usually requires the resident to be titrated to a specific blood level, a single medication error could alter that level and precipitate a reoccurrence of symptoms and toxicity." Review of the facility's policy 7.5 Medication Administration Orals, dated 10/07, revealed the following procedure: "6. Pour the correct number of tablets or capsules into the medication cup." On 1/29/10 at 10:45 AM, during an interview and record review of the Millennium system with E43 (LPN) and E44 (LPN), they confirmed that R18 incorrectly received 400 mg of Dilantin and 10 mg of Lexapro. At 11 AM, E43 and E30 (Nursing Supervisor) called the pharmacy regarding the duplicate automated bags containing the same medications. E30 stated that according to the pharmacy, the automated system malfunctioned and dispensed two bags containing the AM doses of Dilantin and Lexapro. Furthermore, E30 stated that although this was a pharmacy dispensing error, the nurse administering the medications should have caught the duplication in dosage and administered the correct dose.	F 333		
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 63 This REQUIREMENT is not met as evidenced by: Based on observations made in the dietary department and staff interviews, it was determined that the facility failed to prepare, distribute and serve food under sanitary conditions. Findings include: The following observations were made in the kitchen, or in the kitchenette areas of the second and third floor dining rooms: 1. On 1/26/10 at 10:02 AM, observation in the kitchen revealed that the hair restraint failed to completely cover E10's (foodhandler) hair. On 1/27/10 at 9:10 AM, while serving food by the steam table in the third floor kitchenette, E16 (dietary staff) was observed wearing a hair restraint which failed to completely cover her hair. On 2/2/10 at 5:30 PM, E35 (dietary aide) was observed in the 2nd floor kitchenette with a hair restraint not completely covering her hair. Additional observations on 1/29/10 during breakfast and lunch of dietary staff (E36, E37, E38) in the kitchenette areas of the second and third floors of the facility revealed hair restraints not completely covering their hair. Facility procedure review for dietary staff uniforms did not include the use of hair restraints as part of their requirements while working with food. Staff interviews with E16, E35, E36, E37, and E38 confirmed the findings.	F 371	1. All residents may be affected. 2. All residents may be affected. 3. Procedure for hairnet use will be reviewed and revised to include proper hairnet use. Dietary staff will be inserviced on proper use of hairnets. Dietary Manager will review a sampling of dietary personnel hairnet use weekly. Tortillas were removed from referenced area. Food items will not be placed on top shelf under insulated piping. Dietary Manager or designee will inspect Freezer weekly to ensure that food items are not placed in referenced area. Staff will be inserviced regarding storage of food. Scoops have been removed from inside flour bin and top of thickener containers. Lids will be cleaned. Nursing staff and dietary staff will be inserviced regarding the proper procedures for storing scoops. Dietary Manager will check a sampling of thickener containers monthly to ensure that scoops are not stored inside or on top of containers. Dietary Manager or designee will check hot boxes weekly for cleanliness.	4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 64 2. On 1/26/10, two bags of tortillas were observed under the piping connected to the kitchen freezer. E10 stated they were not on the menu for that week and relocated the bags to another location were the potential for contamination was removed. 3. On 1/26/10 at 10:22 AM, one scoop was observed stored inside the flour bin with the handle touching the food. Another scoop was observed on the top of the thickener bin lid unprotected against potential contamination. The lid was observed to be dirty. Additionally on 1/26/10 at lunch, two scoops were observed inside the thickener jar in the third floor dining room kitchenette with their handles touching the thickener, thus contaminating the food. 4. Throughout the survey, observations of the hot box used to store residents food in the second and third floor kitchenettes revealed that the units were dirty and had encrusted food debris inside them. 5. On 1/26/10, observations of the clean coffee cups (3 of 15) stored in the clean racks revealed dirt or stains on the food contact areas of the cups. Upon bringing the concern to the attention of E10 (dietary management), she requested that the utility dietary staff send the cups back into the dishwasher to get them cleaned. Additionally on 1/29/10 at 10:45 AM, observations of food dessert dishes stored in the third floor kitchenette storage racks, under the steam tables, revealed that two (2) of seven (7) dishes were stored dirty or stained. On 2/2/10 at 5:30 PM, observations of food dessert dishes stored in the second floor kitchenette storage racks under	F 371 F371 (cont)	Dietary staff will be inserviced on cleaning procedures for hot boxes. Stained dishes will be cleaned or replaced. Dietary Manager will check a sampling of dishes monthly for stains. Referenced items will be cleaned or replaced. Dish machine area will be kept free from debris. Dietary staff will be inserviced on proper procedures for cleaning. Dietary Manager will inspect dish machine area of kitchen weekly to ensure dish machine area is cleaned according to procedure. Dietary Manager will in-service dietary staff on proper storage of personal gear. Dietary Manager will inspect kitchen weekly for cleanliness. Environmental Services director will have men's bathroom floor cleaned. Environmental Services Director will inspect men's bathroom monthly for cleanliness. Facility Manager will adjust angle of dish machine conveyor to ensure water falls back into dish machine. Dietary Manager will inspect dish machine area monthly to ensure waters falls into appropriate areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 65 the steam tables revealed that one (1) of five (5) dishes were stored dirty. On 2/4/10 at 8:30 AM, two (2) of six (6) stained dessert plates were observed under the steam table of the third floor kitchenette. Interview with E39 (dietary staff) revealed that they use the stained plates during meals if they receive them like that from the kitchen. 6. On 1/26/10, encrusted food debris and grease deposits were observed in the kitchen on the non-food contact surfaces of two frying pans, muffin pans, cake pans stored in the clean rack, and on the garbage compactor unit. Additionally, the following were also observed with dirt, grease deposits or food debris in the kitchen: the wall behind the food kettle, thick deposit of grease on the degreaser tank lid outside the kitchen, black deposits on floor drain grills by the soup kettle, encrusted food debris on the floor of the kitchen, and food debris on the floor of the dry storage area under the food racks. E10 confirmed these findings. 7. On 1/26/10 at 10:10 AM, the dishwasher surface at the entrance and the top of the machine was observed with debris. On 2/2/10 at 5:45 PM, food debris was observed on the entrance surface and top of the dishwasher. The machine was not in operation at the time and had already been cleaned for the day. Stagnant water and debris was observed on top of the garbage compactor. 8. On 1/26/10 at 10:22 AM, a dietary staff's jacket was observed stored on top of the clean food pans in the kitchen's clean rack. E10 was observed removing the jacket from the area. She confirmed the jacket was not supposed to be	F 371 F371 (cont)	4. Dietary Manager, Environmental Services Director and Facility Manager will report findings of their sampled reviews and check to QA. QA team will develop and implement action plans based on findings as necessary.	4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 66 stored in that part of the kitchen. 9. The men's bathroom floor was observed dirty or stained. Interviews with E10 and E11 (Housekeeping Manager) confirmed this finding. 10. Observations of the dishwasher area on 1/26/10 at 10:30 AM revealed a pool of water on both sides of the dishwasher. E10 stated that water was leaking from the gap on the floor and requested dietary utility staff to mop the floor. Water was observed on the floor after staff mopped the floor. E10 stated maintenance staff would be contacted.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F425 1. Medication dispense error was reported to Pharmacy. Resident suffered no ill effects. 2. All residents may be affected. 3. Director of Nursing or designee will assign medication pass competencies which include direct observation to a sampling of nurses monthly. During this review, medication packs will also be checked for correct packaging. 4. Findings will be reported to QA. QA team will develop and implement action plans if necessary based on results of competencies.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services that ensured accurate receiving, dispensing and administering of medications for one resident (R18). Findings include: R18 was admitted to the facility on 2/3/05 with diagnoses that include Epilepsy, Senile Dementia with Delusions and Depressive Disorder. Review of the 12/09 Physician's Order Sheet revealed a 12/17/09 order for Dilantin 100 milligrams (mg) two capsules by mouth two times a day and a 12/8/08 order for Lexapro 5 mg one tablet by mouth one time a day. During a medication administration observation on 1/29/10 at 10:05 AM, E43 removed a soufflé cup from the medication cart. The cup contained a strip of automated packaged bags that were R18's AM medications. E43 opened each bag and poured the medications into the soufflé cup. E43 administered the resident a total of 10 medications, which incorrectly included four 100 mg capsules of Dilantin and two 5 mg tablets of Lexapro. During reconciliation of the medications, it was revealed that there were two Millennium Pharmacy bags with an automated date and time of 1/29/10 at 8 AM. Each bag also showed an automated name and dose of each medication. On 1/29/10 at 11 AM, E43 and E30 (Nurse Supervisor) called the pharmacy regarding the duplicate automated bags containing the same	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 68 medications. E30 stated that according to the pharmacy, the automated system malfunctioned and dispensed two bags containing the AM dose of Dilantin and Lexapro. E30 also stated that the pharmacy dispensing error contributed to the administration error for R18.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure during monthly drug regimen reviews that irregularities and lack of monitoring were reported to the attending physician for two (R17 and R67) sampled residents. Findings include: 1. Review of R67's clinical record revealed that she was on the cholesterol lowering medication Pravachol since admission to the facility on 5/7/09. The only lipid (fat) and liver function studies found in the clinical record were dated 9/12/08. Laboratory tests revealed an elevated cholesterol level of 269 (normal 0-200). Findings were confirmed with E2 (Director of	F428 F 428	1.1 Lab tests were ordered for resident R67. 1.2 All residents who receive statin drugs may be affected. 1.3 Pharmacy consultant will be inserviced on the need to identify residents requiring labs and include missing labs on his report. Pharmacy Consultant will include a report of missing labs for residents on statin drugs. 1.4 QA will review Pharmacy Consultant report and develop action plans as necessary. 2.1 Eye drop order has been corrected for R17. 2.2 All residents receiving eye drops may be affected. 2.3 Pharmacy Consultant will be in-serviced on identifying irregularities in frequency and location of medications. Pharmacy consultant will include in Pharmacy Report any identified order discrepancies for re-admitted residents. 2.4 QA will review Pharmacy Consultant report and develop action plans as needed.	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 69 Nursing) during an interview on 2/1/10, E2 stated that the facility's practice was to check lipid profiles every 6 months. E2 confirmed that R67 failed to receive proper monitoring for Pravachol since being admitted to the facility 7 months earlier. The licensed pharmacist failed to identify during monthly drug regimen reviews that lipid and liver function labwork was not done for R67 and subsequently, the attending physician was not notified. 2. On 11/19/10, R17 was readmitted to the facility post hospitalization due to a stroke. Additionally, R17 had a diagnosis of glaucoma and was receiving Cosopt ophthalmic solution 1 drop to the right eye twice a day. The readmission orders, dated 11/19/10 stated, "Cosopt ophthalmic solution 1 gtt. (drop) left eye daily" (should have been to the right eye). Review of the 11/09 Medication Administration Record (MAR) revealed that beginning 11/20/09, R17 received Cosopt ophthalmic solution 1 drop to the right eye daily. On 11/24/09, a Medication Regimen Review (MRR) was done by the consultant pharmacist who checked, "No Irregularities Noted" despite the discrepancy between the POS (physician's order sheet) and MAR. The facility failed to have a consultant pharmacist identify the irregularity in the frequency of use and which eye was to receive the eye drop medication, Cosopt during the MRR. On 2/2/10, E2 (DON) confirmed these findings.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 70 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441 F441	1.1 Infection control Program was updated to monitor organism and locations within the facility to better control, investigate and prevent infections. 1.2 All residents may be affected. 1.3 Infection Control Meetings will be conducted at least monthly. Infection Control Nurse will track the types of infections, organisms and locations at least monthly. 1.4 Infection reports will be submitted to QA monthly. Action Plans will be developed as needed. 2-5.1: All Residents may be affected. 2-5.2 All residents may be affected. 2-5.3: Housekeeping/laundry staff will be inserviced and wear disposable gloves when handling soiled linen. Environmental Services Director will observe staff weekly to ensure disposable gloves are worn while handling soiled linen. Housekeeping/laundry staff will be in-serviced to dispose of gowns in hazardous waste container. Environmental Services Director will observe staff weekly for proper	4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 71 Based on observations, review of facility documents and staff interviews, it was determined that the facility failed to follow recommended handling, washing and storing of soiled linen and failed to maintain an infection control program regarding ongoing surveillance. Findings include: 1. On 2/1/10 at 12:45 PM, during review of the facility's Infection Control Policy and 2009 Monthly Infection Records with E2 (Director of Nursing) and E30 (Nursing Supervisor) the following was revealed: in 4/09 and 11/09 there were 10 Urinary Tract Infections (UTI's) documented for the second floor residents and in 10/09, there were 11 UTI's on the second floor. E2 stated that she was unable to determine who the individual residents were, what organisms caused the UTI's and if the infections were located in the same hallway. Furthermore, E2 stated that the contracted service responsible for the monitoring and tracking of their infections ended in January of 2009. On 2/1/10 at 2:30 PM, E2 and E30 stated that the facility did not have a formalized monitoring and tracking system in place to control, investigate and prevent infections in the facility. E1 (administrator) was interviewed on 2/5/10. E1 denied that the facility had a problem with infection control, he stated they were following trends and looking for patterns, and stated that UTI's were ranging 10-15, they were not exceeding those amounts and that an action plan was not warranted. The total amount of UTI's (for both second and third floor residents) for 10/09 was 17, above the stated normal facility range of 10-15. Review of Monthly Infection Records from 1/09 through 12/09 additionally revealed that the	F 441 F441 (cont)	disposal of soiled gowns. Procedure was changed to remove "staff should repeat the cycle." Environmental Services Director has removed outdated section from procedure and implemented a revised procedure using the correct cycle for isolation laundry. Environmental Services Director will in-service staff on laundry cycles and observe staff monthly to ensure proper cycles are used. Procedure for transporting soiled linens will be amended to reflect that chute room on nursing floors is the receiving area. Soiled linen receiving room in basement will have mechanical ventilation installed. Chute door will be repaired to stay closed. Procedure for transporting soiled linens will be amended to reflect that chute room on nursing floors is the receiving area. Soiled linen receiving room in basement will have mechanical ventilation installed. Chute door will be repaired to stay closed. Nursing staff will be inserviced regarding revised procedure. Facility Manager will check operation of ventilation fans. Nursing staff will be inserviced regarding changes to procedures. Housekeeping/laundry staff will be inserviced on proper	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 72 second floor consistently had more UTI's than the third floor. Even though E1 claimed that they were able to follow trends and patterns in the prevalence of infections, it was not clear how this could be done since according to E2 and E30, they were not tracking the organisms and locations of the infections. Surveyors asked facility staff for any additional information to show that they were doing more monitoring, but none was provided. 2. Review of the facility procedures entitled "Soiled Linen Processing" , "Washing, Supplement to Procedure #26 ", "Laundering of Contaminated Linens and Materials, Departmental Procedure #25", and other procedures related to clean/soiled linen handling procedures were reviewed. An observation of the handling and washing of soiled linen from resident rooms on contact precaution (infectious linen) on 2/2/10 at 11:00 AM revealed that laundry staff failed to follow the facility's infection control procedures as follows: a. Facility procedure stated that the staff needed to wear disposable gloves. E32 (housekeeping/laundry staff) was observed using re-usable latex gloves which she washed with soap and water after placing the soiled (infectious) linen in the washer. E32 was then observed moving from clean to dirty areas of the laundry without removing the gloves. This has the potential for carrying the infection from soiled area to the clean linen areas. b. Facility procedure stated that laundry staff should place their dirty gloves and gowns in a	F 441 F441 (cont)	techniques for handling soiled linen. Environmental Services Director will observe staff weekly for proper handling of soiled linen. Hot water will reach 160F. Facility Manager will keep a log of hot water temperature. Exhaust fans will be installed in referenced areas. Facility Manager will check for negative air flow from a sampling of soiled linen collection areas monthly. 2-5.4: Facility Manager and Environmental Services Director will submit findings of rounds and checks to referenced items to QA. QA team will develop and implement actions plans based on findings of reports.	4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 73 clean coded liner for disposal, "to treat disposable gloves, gowns, liners as hazardous waste." E32(laundry aide) was observed placing the dirty (infectious) gown in the regular trash barrel stored in the washer area without the liner. Staff interview with E11 (Housekeeping Manager) revealed that the staff was supposed to place the gown in the red bag which E32 failed to do. c. Facility procedure stated that at the end of the wash cycle, "the staff should repeat the cycle". Interview with E32 on 2/2/10 revealed that after the washer cycle is completed, she places the washed linen on a cart and then takes the washed linen to the dryer next door. E32 revealed that single washing of the linen was done as opposed to "double" washing per facility procedure. d. Review of facility procedures revealed that bags of soiled linen from resident rooms on contact precaution were supposed to be taken to the receiving area of the laundry. Interview with E21 and E46 (Certified Nurse's Aides) revealed that they drop the yellow bags of soiled linen (residents on contact precautions) down the linen chutes on the second and third floors. The soiled linen receiving room in the basement from the chutes was not ventilated to the outside nor did it have any mechanical ventilation. Throughout the survey, the chute door remained open when soiled linen bags were dropped into the chute and after the delivery of the bag was done. 3. On 2/1/10, a laundry staff was observed shaking soiled bed linen after removing it from the bags in the receiving area. On 2/2/10 at 11:00 AM, E32 was observed placing the contents of the yellow bags of contact precaution linen and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 74 unbagged bed linen inside the washer. Interview with E32 revealed that the unbagged linen should have been bagged before getting to the laundry areas. She stated that they get unbagged linen in the chutes at times and they don't know if this is linen from resident rooms that are on contact precautions. E32 stated that when they get the bed linen unbagged, they wash it with the linen in the yellow bags. 4. Observation on 2/2/10 of the washer hot water temperatures (in the boiler room) revealed the temperature to be 152 degrees Fahrenheit. Interview with E11 and E9 (Facility Manager) revealed that this was the maximum temperature of the washer water temperatures as the unit only provided this temperature (or lower) and did not go any higher. E9 and E11 stated that the washer had no temperature booster to raise the temperature to at least 160 degrees Fahrenheit. Interview on 2/2/10 with the facility's chemical vendor for the washers revealed that the bleach used in the washers was for the removal of stains only, not for sanitizing. On 2/8/10, interview with the chemical vendor management and E11 revealed that the chemicals did not provide the necessary concentration to meet the regulations. They stated that the concentration required by the regulations would break down the linens. They stated that the only solution was to increase the temperature of the water. 5. The washer area of the laundry had no mechanical ventilation to remove dirty air outside the building. The area was not maintained under a relative negative pressure. Additionally, on 2/1/10 at 2:10 PM, the 2nd floor oxygen room exhaust ceiling vent was not	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 75 exhausting the air out of the room. The soiled linen chute and soiled yellow bags are kept in the room. The soiled linen chute in the basement had no exhaust vent. The room is used to store soiled linen and infectious linen.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain the call system for the second floor and third floor common bathrooms. Findings include: Observation of the resident common bathrooms on the second and third floors on 1/26/10 revealed that the call systems were malfunctioning (did not light up or sound at the telephone panel). The concern was brought to the attention of E30 (RN Supervisor). Observations of the second floor resident common bathroom on 1/29/10 at 7:55 AM revealed that the alarm was not fixed and was still not functioning. The concern was brought to the attention of E2 (Director of Nursing). Observation of the second floor resident common bathroom on 2/2/10 revealed that the call bell system was still malfunctioning (overhead light fixed but no sound or display on telephone). Interview with the E9 (Facility Manager) revealed that the system was being worked on and repairs	F 463 F463	1. Referenced call bells have been repaired. 2. All residents may be affected. 3. Facility Manager will check a random sample of call bell monthly for proper operation. 4. Findings of Facility Manager's review will be submitted to QA. QA will develop and implement action plans as needed.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 76 had not been completed. Interview with E9 on 2/4/10 revealed that although they had a new computerized maintenance tracking system, there was no system in place for regular monitoring of the call light system to ensure that they were functioning.	F 463		
F 464 SS=B	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide adequate furnishings in their dining rooms to accommodate different residents' physical needs. Dining table heights were too high for four residents (R24, R28, R45 and R46). Findings include: Resident Council meeting minutes for 12/4/09 and 1/8/10 were reviewed. The 12/4/09 minutes stated that residents complained that some of the tables in the dining rooms were too high. The minutes indicated that, "All tables will be checked, leveled and measured for height." In the 1/8/10 minutes, under "Old Business", it stated, "Tables measured and leveled - still seem too high." 1. During dining observations in the third floor	F 464 F464	1. All residents may be affected. 2. All residents may be affected. 3. Facility Manager will replace floor leveling hardware with self leveling floor hardware. This will reduce the height of residents table. Facility Manager will check a sample of tables for proper operation of leveling hardware monthly. 4. Facility Manager will submit findings of tours to QA. QA will develop action plans as needed.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 464	Continued From page 77 dining room on 1/26/10 during the mid-day meal, R45 was observed sitting low to the table. When asked if she was sitting up high enough, she stated that she was too low and too far from the table. 2. During dining observations in the third floor dining room on 1/26/10, R24 was observed sitting low to the table. When asked if she would like to sit higher up, she responded, "They wouldn't give it to you anyway." 3. R28 was observed sitting in the second floor dining room on 2/2/10 at 8:25 AM. The resident stated that the table was too high for her and caused her to spill her food. She stated that she has talked about the problem in resident council, but no one has told her what could be done to correct it. 4. On 2/5/10, R46 who sits low in her wheelchair, was asked if the tables in the dining room were too high for her and she answered, "yes." On 2/5/10, during an interview with E10 (Food Service Director), she stated that the dining tables had missing parts that did not allow them to adjust the table heights for the residents. She stated that the parts had been ordered. On 2/5/10, during an interview with E9 (Facility Manager), he stated that they had obtained estimates on self-adjusting feet for the dining tables, however, he was told by the administration to hold off ordering them. The facility failed to respond to residents' complaints regarding the height of the dining tables and neglected to make the necessary	F 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 464	Continued From page 78 modifications to the furnishings to accommodate the residents' needs.	F 464		
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on inservice documentation reviews and staff interviews, it was determined that the facility failed to ensure that nine (9) sampled staff were trained in emergency procedures when they began work at the facility or periodically thereafter. Findings include: Facility in-service records were reviewed for six (6) CNA's and three (3) nurses. 1. E18 (CNA) had no emergency preparedness training upon hire or periodically thereafter. 2. E19 (CNA) had no emergency preparedness training upon hire or periodically thereafter. 3. E20 (CNA) had no emergency preparedness training upon hire or periodically thereafter. 4. E21 (CNA) had no emergency preparedness training upon hire or periodically thereafter. Interview with E21 on 1/29/10 confirmed this finding. 5. E22 (CNA) had no emergency preparedness	F 518	F518 1. In-servicing for emergency preparedness will be provided for all staff. 2. All residents may be affected. 3. Emergency preparedness education will be included in orientation and annually thereafter. Staff Development will maintain records of emergency preparedness in-services. 4. Staff development will submit report of in-services given each month to QA. QA team will develop and implement action plans as needed.	4/6/10 4/6/10 4/6/10 4/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 79	F 518		

training upon hire or periodically thereafter.

6. E24 (CNA) had no emergency preparedness training upon hire or periodically thereafter.

7. E13 (nurse) had no emergency preparedness training upon hire or periodically thereafter. Interview with E13 on 1/29/10 confirmed this finding.

8. E23 (nurse) had no emergency preparedness training upon hire or periodically thereafter. Interview with E23 on 1/29/10 confirmed this finding.

9. E31 (nurse) had no emergency preparedness training upon hire or periodically thereafter. Interview with E31 on 1/29/10 confirmed this finding.

During an interview with E17 (Staff Development) on 2/1/10, she stated that emergency preparedness training was not included in their training for new hires or ongoing.

During staff interviews with E13, E17, E21 and E23 on 1/29/10, they stated that, other than fire training, they were not familiar with what to do in the event of a missing person and/or hurricane emergency as stated in the facility's Disaster Preparedness procedures. On 2/1/10, interviews with E17 and E31 revealed that a drill was conducted on the weekend to address missing person procedures. They stated that they established a code "E" for missing person which they never had. On 2/1/10, the concern was brought to the attention of E2 (Nursing Director) on 2/1/10. On 2/1/10, E2 provided record of an emergency training conducted on 1/6/10 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 02/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 80 Elopement. 18 staff were trained during this in-service. Review of the facility Disaster Preparedness Plan revealed that missing persons and hurricanes were included as part of the emergency preparedness procedure. The Disaster Preparedness plan did not include bomb threat procedures, although it was listed as an emergency in the facility's plan. The procedure did not state that employees would be trained periodically after the New Employee Orientation training. Review of the "New Employee Orientation Staff Development Policy and Procedure" for the facility revealed that emergency preparedness training was missing from the list of training. Only fire was listed as part of the orientation training. Additionally, missing persons or elopement training was missing from the "New Employee Orientation" training checklist. The Facility "Individual Orientation Record" did not list emergency preparedness as part of the training required by new employees other than fire.	F 518		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from January 26, 2010 through February 5, 2010. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 94. The survey sample totaled 83 residents, which included 40 census residents, 9 admission residents and 33 stage 2 residents. Additionally, there was 1 subsampled resident.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.6.0	**Services To Residents**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.**	

Provider's Signature _____ Title Administrator Date 3/18/10

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from January 26, 2010 through February 5, 2010. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 94. The survey sample totaled 83 residents, which included 40 census residents, 9 admission residents and 33 stage 2 residents. Additionally, there was 1 subsampled resident.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.6.0	**Services To Residents**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.**	

Provider's Signature [signature] NHA Title Administration Date 3/8/10

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L, survey date completed 2/5/10, F157, F246, F309, F310, F312, F317, F318, F323, F325, F329, F333, F425, F428, and F464.	Cross-refer to CMS 2567-L, survey date completed 4/6/10, F157, F246, F309, F310, F312, F317, F318, F323, F325, F329, F333,F425, F428, and F464.
3201.6.5	**Nursing Administration**	
3201.6.5.2	**Treatments and medications ordered by a physician shall be administered using professionally accepted techniques in accordance with 24 Delaware Code, Chapter 19.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 2/5/10, F281.	Cross-refer to CMS 2567-L, survey date completed 4/6/10, F281.
3201.6.5.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.**	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L, survey date completed 2/5/10, F280.	Cross-refer to CMS 2567-L, survey date completed 4/6/10, F280.
3201.6.9	**Housekeeping and Laundry Services**	
3201.6.9.5	**The facility's handling, storage, processing and transporting of linens shall comply with facility infection control policies and procedures.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/5/10, F441, example #3.	Cross-refer to CMS 2567-L survey date completed 4/6/10, F441, example #3.
3201.6.12	**Communicable Diseases**	
3201.6.12.1.3	**The nursing facility shall ensure that the necessary precautions stated in the policies and procedures are followed.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/5/10, F441 example #2 and #3.	Cross-refer to CMS 2567-L survey date completed 4/6/10, F441 example #2 and #3.
3201.6.13	**Infection Control**	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.13.1	**Infection Control Committee**	
3201.6.13.1.5	**The infection control coordinator shall maintain records of all nosocomial infections and corrective actions related to those infections to enable the committee to analyze clusters or significant increases in the rate of infection and to make recommendations for the prevention and control of additional cases.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/5/10, F441 example #1.	Cross-refer to CMS 2567-L survey date completed 4/6/10, F441 example #1.
3201.7.0	**Plant, Equipment and Physical Environment**	
3201.7.3	**Facility Systems Requirements**	
3201.7.3.4	**The facility shall be equipped with a resident call system which meets the current standards of the Guidelines for Design and Construction of Health Care Facilities.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 2/5/10, F463.	Cross-refer to CMS 2567-L, survey date completed 4/6/10, F463.

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.5 3201.7.5.1	**Kitchen and Food Storage Areas** **Facilities shall comply with the Delaware Food Code.** Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 2-402.11, 3-305.11, 4-601.11, 6-501.11, 6-501.110, and 6-501.114 of the State of Delaware Food Code. Findings include: **Hair Restraints** **2-402.11 Effectiveness.** **(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 2/5/10, F371 example #1.	Cross-refer to CMS 2567-L, survey completed 4/6/10, F371 example #1.

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	3-304.12 In-Use Utensils, Between-Use Storage. **During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored:** **(B) In food that is not potentially hazardous with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon;** **(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous; or** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 2/5/10, F371 example #3. **3-305.11 Food Storage.** **(A) Except as specified in ¶¶ (B) and (C) of this section, food shall be protected from contamination by storing the food:** **(1.) In a clean, dry location;** **(2) Where it is not exposed to splash, dust, or other contamination; and**	Cross refer to CMS 2567-L, survey completed 4/6/10, F371 example #3.

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	(3) At least 15 cm (6 inches above the floor). **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 2/5/10, F371 example #2. **4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.*** **(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch.** **(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.** **(C) Non-food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/5/10, F371 examples #4 through #7. **6-501.11 Repairing.** **The physical facilities shall be maintained in good repair.**	Cross refer to CMS 2567-L, survey date completed 4/6/10, F371 example #2. Cross-refer to CMS 2567-L survey date completed 4/6/10, F371 examples #4 through #7.

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 2/5/10, F371 example #10. **6-501.110 Using Dressing Rooms and Lockers.** **(A) Dressing rooms shall be used by employees if the employees regularly change their clothes in the establishment.** **(B) Lockers or other suitable facilities shall be used for the orderly storage of employee clothing and other possessions.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/5/10, F371 example #8. **6-501.114 Maintaining Premises, Unnecessary Items and Litter.** **The premises shall be free of:** **(B) Litter.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/5/10, F371 examples #6 and #9.	Cross-refer to CMS 2567-L survey date completed 4/6/10, F371 example #10. Cross-refer to CMS 2567-L survey date completed 4/6/10, F371 example #8. Cross-refer to CMS 2567-L survey date completed 4/6/10, F371 examples #6 and #9.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.6	**Sanitation and Laundry**	
3201.7.6.3	**For on-site laundry processing, the facility shall:**	
3201.7.6.3.1	**Provide a room under negative air pressure for receiving, sorting, and washing soiled linen. Washers must be supplied with hot water of 160° F.**	
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L survey date completed 2/5/10, F441 examples #4 and #5.	Cross-refer to CMS 2567-L survey date completed 4/6/10, F441 examples #4 and #5.
3201.8.0	**Emergency Preparedness**	
3201.8.4	**The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.**	
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L survey date completed 2/5/10, F518.	Cross-refer to CMS 2567-l survey date completed 4/6/10, F518.

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
16 Del. C., Chapter 11, Subchapter II, §1108	**Posting of inspection summary and other information and public meetings.** **(a) Each facility shall prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees and visitors the following:** **(4) A notice in the form prescribed by the Department stating that informational materials relating to the compliance history of the facility are available for inspection at a location in the facility specified by the sign. The notice shall also provide the telephone number to reach the Division to obtain the same information concerning the facility.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/5/10, F167.	Cross-refer to CMS 2567-L survey date completed 4/6/10, F167.
16 Del. C., Chapter 11, Subchapter II, § 1121	**Patient's rights.** **It is the intent of the General Assembly, and the purpose of this section, to promote the interest and well-being of the patients and residents in sanitoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interest of the patient shall be protected by a**	

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following: **(1) Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/5/10, F241. **(12) Each patient and resident has the right to manage the patient's or resident's financial affairs. If, by written request signed by the patient or resident, or by the guardian or representative of a patient or resident who has been adjudicated incompetent, the facility manages the patient's or resident's financial affairs, it shall have available for inspection a monthly accounting, and shall furnish the patient or resident and the patient's or resident's family or representative with a**	Cross-refer to CMS 2567-L survey date completed 4/6/10, F241.

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	quarterly statement of the patient's or resident's account. The patient and resident shall have unrestricted access to such account at reasonable hours. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/5/10, F159.	Cross-refer to CMS 2567-L survey date completed 4/6/10, F159.
16 Del. C., Chapter 11, Subchapter IV, § 1141	**Criminal background checks.** **(c) No employer who operates a nursing home or a management company or other business entity that contracts to operate a nursing home may hire any applicant without obtaining a report of the person's entire criminal history record from the State Bureau of Identification and a report from DHSS regarding its review of a report of the person's entire federal criminal history pursuant to the Federal Bureau of Investigation appropriation of Title II of Public Law 92-544.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/5/10, F226	Cross-refer to CMS 2567-L survey date completed 4/6/10, F226.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: February 5, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED